## CHAPTER 3: INDUSTRY SNAPSHOT: HOSPITALS

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## I. OVERVIEW

This chapter describes how hospitals are paid, trends in hospital pricing, the pressures hospitals face, and delivery innovations, including hospital networks. Chapter 3 considers a number of current controversies, including payor complaints that hospitals are exercising market power and hospital complaints about single- specialty hospitals. Chapter 3 also examines how government purchasing of hospital services affects the health care marketplace.

The next chapter considers hospital competition law issues, beginning with mergers. Chapter 4 describes and evaluates geographic and product market definitions, entry and efficiency issues, and the significance of a hospital's non-profit status. Chapter 4 also describes group purchasing organizations, their potential efficiencies, structure and incentives, contracting practices, and *Health Care Statement* 7.

Representatives from hospitals and hospital organizations, as well as legal, economic, and academic experts, and government officials spoke at the Hearings. Hospital topic panels included Perspectives on Competition Policy and the Health Care Marketplace (February 27); A Tale of Two Cities (February 28, April 11); Hospital Round Table (March 26); Defining Product Markets for Hospitals (March 26); Defining Geographic Markets for Hospitals (March 26); Single Specialty Hospitals (March 27); Contracting Practices (March 27); Issues in Litigating Hospital Mergers (March 28); Hospitals - Horizontal Networks and Vertical Arrangements (April 9, 2003); Hospitals - Non-profit Status (April 10); Hospital Joint Ventures and Joint Operating Agreements (April 10); Hospitals - Post-Merger Conduct (April 11); Physician Hospital Organizations (May 8, 2003); Quality and Consumer Information: Hospitals (May 29); and Group Purchasing Organizations (September 26).[1] Many industry representatives and experts also testified at the Commission's 2002 Health Care Workshop.[2]

## II. INTRODUCTION

In cities and towns throughout the United States, hospitals are a key part of the health care delivery system. Hospitals are there when Americans give birth or die, are injured, or live with a chronic illness. Hospitals respond to the health care challenges in their communities, whether the problem is SARS or syphilis, anthrax or chicken pox, obesity or influenza. Hospitals provide care to the rich and poor, the well insured and the uninsured.

Currently, payments to hospitals for inpatient care account for approximately 31 percent

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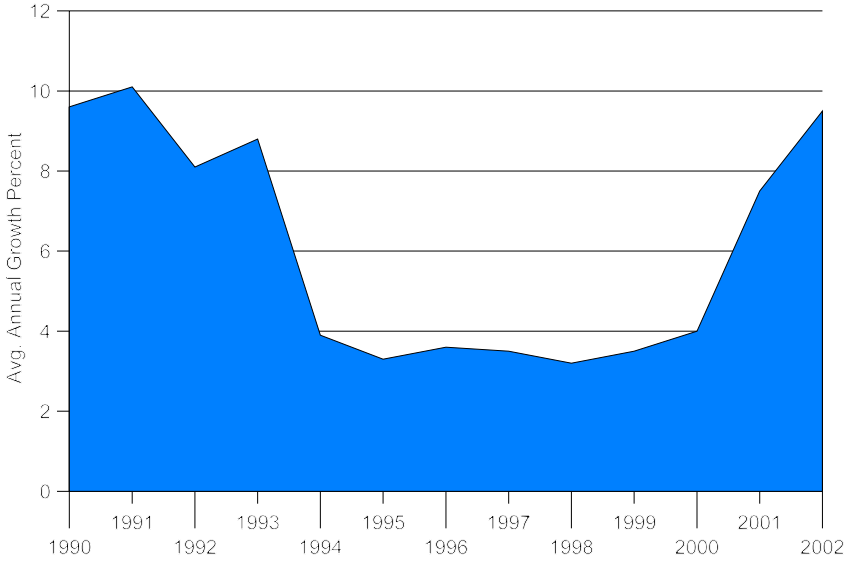
[1] For lists of participants in these and other panels *see infra* Appendix A and in the Agenda, *at* http://www.ftc.gov/ogc/healthcarehearings/completeagenda.pdf.

[2] A list of participants in the September 2002 FTC Health Care Workshop is available at http://www.ftc.gov/ogc/healthcare/agenda.htm.

of total health care expenditures in the United States.[3] The percentage of total expenditures devoted to inpatient care has declined over the past two decades, along with declines in hospital length-of-stay and the per capita rate of hospitalization.[4]

Figure 1: National Hospital Care Expenditures
Average Annual Growth from Prior Year




During the period 1993-98, spending on hospital inpatient care increased by 3.4 percent per year. The past four years have seen annual increases that are double or triple that amount.[5]

Figure 1 illustrates how hospital expenditures and expenditure growth have accelerated in recent years, after modest or negative growth during the prior five years.[6] Expenditures for inpatient care for the next two years are projected to grow by approximately 6.2 percent per year.[7]

Federal and state governments are responsible for almost 60 percent of payments to

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[3] Katharine Levit et al., *Health Spending Rebound Continues in 2002*, 23 HEALTH AFFAIRS 147, 155 (Jan./Feb. 2004).

[4] CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS), THE CMS CHART SERIES, PROGRAM INFORMATION ON MEDICARE, MEDICAID, SCHIP, AND OTHER PROGRAMS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES §1, at 16, 18 (2002), *available at* http://www.cms.hhs.gov /charts/series/.

[5] Levit, *supra* note 3, at 154-55.

[6] Centers for Medicare & Medicaid Services, *Health Accounts: National Health Expenditures 1965-2013, History and Projections by Type of Service and Source of Funds: Calendar Years 1965-2013*, *at* http://www.cms.hhs.gov /statistics/nhe/default.asp#download (last modified Mar. 24, 2004).

[7] Stephen Heffler et al., *Health Spending Projections Through 2013*, 2004 HEALTH AFFAIRS (Web Exclusive) W4-79, 89, *at* http://content. healthaffairs.org/cgi/reprint/hlthaff.w4.79v1.pdf.

hospitals for inpatient care.[8] For some services, the Centers for Medicare & Medicaid Services (CMS) is the sole payor.[9] CMS's substantial share of hospital spending influences the rest of the financing and delivery markets for hospital services.

Although CMS uses an administered pricing system for Medicare, hospitals engage in non-price competition to attract Medicare and Medicaid beneficiaries, and engage in price and non-price competition for private payors and patients. As detailed below, competition in the market for hospital inpatient services has enhanced quality and lowered prices. Private and public payors are encouraging these improvements by giving providers financial and nonfinancial incentives to increase quality and disseminate quality-related information to patients.[10]

## III. DESCRIPTION OF HOSPITALS

Hospitals fall into one of three categories: (1) publicly owned hospitals, (2) nonprofit hospitals, and (3) for-profit hospitals. Although these classifications might appear distinct and immutable, they are not. Many nonprofit hospitals own for-profit institutions or have for-profit subsidiaries. For-profit systems manage nonprofit and publicly owned hospitals. Hospitals also may change their institutional status. One study demonstrated that over a thirteen year period, approximately one percent of hospitals changed their institutional status every year.[11]

Nonprofit hospitals currently make up about 61 percent of community hospitals and have roughly 71 percent of inpatient beds.[12] For-profit hospitals comprise approximately 15 percent of community hospitals and 13 percent of inpatient beds. The remaining 24 percent of community hospitals are run by federal, state, and local governments, and account for 16 percent of inpatient beds. Figure 2 shows the distribution of beds among the categories of hospitals and

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[8] *See* Levit, *supra* note 3, at 154. Because private insurance tends to cover a younger and typically healthier population, it accounts for a smaller share of overall health care spending. *See also* Scully 2/26 at 27 (estimate by former Administrator of CMS that it is responsible for 40-50% of the average hospital's gross revenue).

[9] CMS was previously known as the Health Care Financing Administration (HCFA). CMS is responsible for administering the Medicare program and oversight of the administration of the Medicaid program by individual states. Day-to-day claims processing for the Medicare program is handled by approximately fifty carriers and intermediaries. CMS is the sole payor for End Stage Renal Disease care and is a significant payor for cataract surgeries.

[10] *See supra* Chapter 1.

[11] Jack Needleman et al., *Hospital Conversion Trends*, 16 HEALTH AFFAIRS 187, 189-90 (Mar./Apr. 1997). Every conceivable conversion permutation occurred; for-profits converted to nonprofits and public hospitals; public hospitals converted to for-profits and nonprofits; and nonprofits converted to for-profits and public hospitals. *Id*.

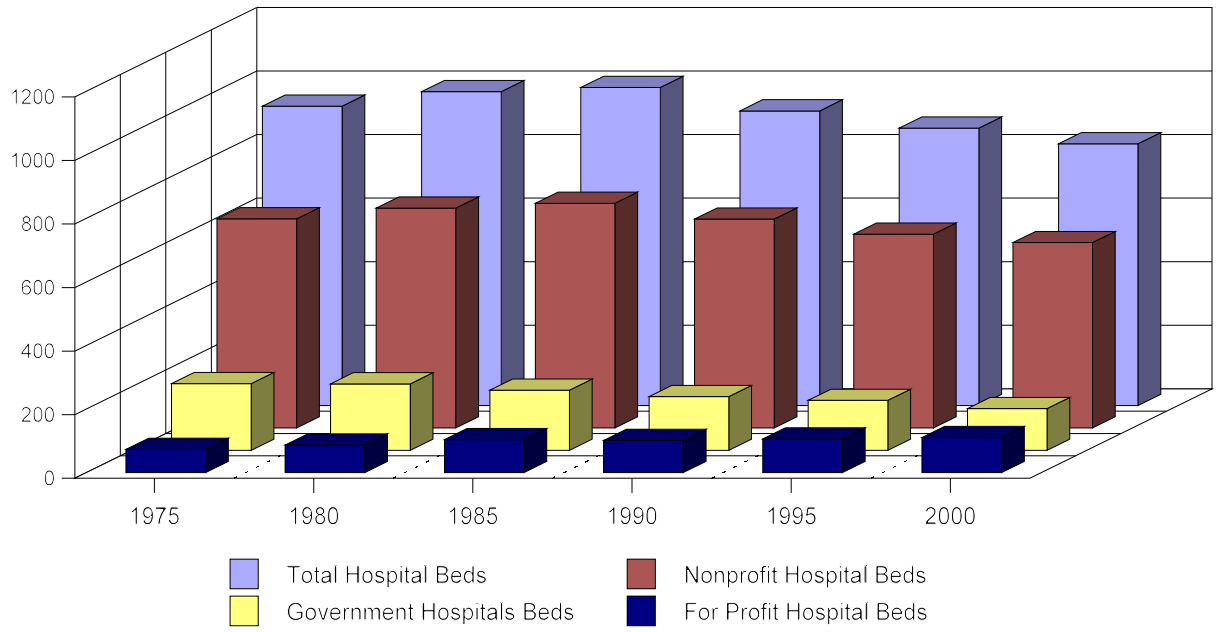
[12] The American Hospital Association defines a community hospital as "all nonfederal, short-term general, and special hospitals whose facilities and services are available to the public." In 2002, there were approximately 1,136 state and local government hospitals, 3,025 nonprofit hospitals, and 766 for-profit hospitals that are classified as community hospitals. AMERICAN HOSPITAL ASS'N, HOSPITAL STATISTICS 2 tbl.1 (2004 ed.).

shows that these patterns have not changed significantly over the past thirty years.[13]

Hospitals are also frequently categorized as primary, secondary, tertiary, and quaternary, dependent on the level and complexity of care provided. For example, a primary care hospital offers basic services such as an emergency department and limited intensive care facilities. A secondary care hospital generally offers primary care, general internal medicine, and limited surgical and diagnostic capabilities. A tertiary care hospital provides a full range of basic and sophisticated diagnostic and treatment services, including many specialized services.

[13] AMERICAN HOSPITAL ASS'N, *supra* note 12, at 2 tbl.1.

Figure 2: Community Inpatient Beds (in thousands)




A quaternary hospital typically provides sub-specialty services, such as advanced trauma care and organ transplantation. These distinctions, however, are not always clear in practice, as hospitals are not restricted to only offering the services associated with one category.

Hospitals provide either general inpatient services or specialize in a particular kind of patient (*e.g.*, pediatric and women's hospitals) or condition (*e.g.*, cardiac, orthopedic, psychiatric and rehabilitation hospitals).

Regardless of how one categorizes private hospitals, they face similar market pressures and competitive constraints. Hospitals seek to provide cost-effective care and generate sufficient margins to continue to provide care to the community. Indeed, it is a misnomer to use the word "nonprofit;" as hospital administrators are fond of saying, "no margin, no mission."[14]

## IV. HOW ARE HOSPITALS PAID: A HISTORICAL PERSPECTIVE

Prior to 1983, Medicare and most other insurers paid hospitals on a cost-based

[14] LAURIE E. FELLAND ET AL., THE HEALTH CARE SAFETY NET: MONEY MATTERS BUT SAVVY LEADERSHIP COUNTS 4 (Ctr. for Studying Health Sys. Change, Issue Brief No. 66, 2003), *available at* http://www.hschange.org/CONTENT/591; Michigan Health & Hospital Ass'n, *No Margin No Mission: The Financial Realities of Michigan's Nonprofit Hospitals*, *at* http://members.mha.org/margin/ (last visited July 7, 2004).

reimbursement system.[15] Under the cost-based reimbursement system, hospitals informed payors of the cost of the care that was provided, and those amounts were then paid. Although there were some constraints on how much a hospital could claim as its costs, the result was to reward volume and discourage efficiency. Payors picked up the cost of each service, each ordered test, and each day in the hospital. Additionally, comprehensive health insurance (both private and public) imposed minimal out-of-pocket costs on patients. Thus, insured patients had little incentive to select lower cost procedures or more efficient providers. As a passive payor of bills, the payor had no control over expenditures.

This payment system led to substantial increases in health care spending. Payors sought to curb these costs through various methods. Medicare implemented a prospective payment system in 1983, and has experimented with a range of strategies for creating incentives for hospitals to constrain their pricing. Private payors have done the same, in many instances piggy-backing off strategies developed by CMS. Medicaid programs have also adopted their own pricing strategies. The rise of managed care and other delivery-side innovations have also had a significant impact on hospital pricing.[16]

### *A. Public Payors*

The most significant public payor is CMS, which administers the Medicare and Medicaid programs. In 1983, Congress directed CMS largely to abandon cost-based reimbursement for acute inpatient care delivered to Medicare beneficiaries, and adopt the inpatient prospective payment system (IPPS).[17] The IPPS was intended to moderate the rising federal expenditures, create a more "competitive, market-like environment, and … curb inefficiencies in hospital operations engendered by reimbursement of incurred cost."[18] Under the IPPS, the amount a hospital receives for treating a patient is based on the diagnosis-related group (DRG) for the episode of hospitalization. The DRG assigned to a particular episode of hospitalization is based on the diagnosis at discharge that justified the hospitalization. Each DRG has a payment weight assigned to it, based on the average cost of treating patients in that DRG. The average DRG cost reflects both the very ill patients that require more intensive care and the "healthy" ill who do not cost as much to treat. Hospitals receive this predetermined amount regardless of the actual cost of care.

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[15] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 385 (1983).

[16] *See supra* Chapter 1.

[17] Some specialty hospitals are excluded from the IPPS. Psychiatric hospitals, pediatric hospitals, and certain designated cancer hospitals remain under a cost-based system of reimbursement. CMS, however, has recently proposed a regulation to shift psychiatric hospitals to prospective payment methods as well. Long-term hospitals (average length of stay is at least 25 days) and rehabilitation hospitals are paid under a prospective payment system that differs from the IPPS but operates on the same principle.

[18] Gregory C. Pope, *Hospital Nonprice Competition and Medicare Reimbursement Policy*, 8 J. HEALTH ECON. 147 (1989).

Certain hospitals receive an adjusted payment in excess of the standard DRG amount. Teaching hospitals and hospitals treating a disproportionate share of low-income patients receive higher payments.[19] All DRGs include a wage index, tied to the geographic location of the hospital. Moreover, if the treatment of a particular patient is exceptionally costly, an "outlier" adjustment is added.[20]

Prior to August 1, 2000, CMS paid hospitals for outpatient care on a cost-based system. Since that date, hospitals, pursuant to the Balanced Budget Act of 1997, are paid for outpatient care under the outpatient prospective payment system (OPPS). Under OPPS, hospitals receive a predetermined amount for all outpatient services or procedures, based on which one of the approximately 750 ambulatory payment classifications (APCs) the episode of care falls into. The OPPS encompasses all evaluation and management services and procedures provided by hospitals on an outpatient basis. For example, the APC for a particular outpatient surgical procedure includes payment for all operating and recovery room services, anesthesia, and surgical supplies. Each APC is assigned a general weight based on the median cost of providing the service.[21]

Effective October 1, 2000, Medicare adopted a prospective payment system for home health care services.[22] Moreover, as of 2007, Medicare is scheduled to begin employing a competitive bidding system to determine which providers will offer durable medical equipment to Medicare beneficiaries.[23]

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[19] *See* Centers for Medicare & Medicaid Services, *Acute Inpatient Prospective Payment System*, *at* http://www.cms.hhs.gov/providers/hipps /ippsover.asp (last modified Mar. 10, 2003). These adjustments were made because Congress concluded that Medicare should pay more to hospitals that incurred greater expenses as a result of having a residency program, or having more patients who were poor. *See generally* SEC'Y OF THE U.S. DEP'T OF HEALTH & HUMAN SERVICES, HOSPITAL PROSPECTIVE PAYMENT FOR MEDICARE: REPORT TO CONGRESS 48-49 (1982). *See also* COMM. ON WAYS & MEANS, BACKGROUND MATERIAL AND DATA ON THE PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS, H.R. REP. NO. 108-6, § 2, at 2-32, 2-44 (2004 Green Book), *available at* http://waysandmeans.house.gov /Documents.asp?section=813.

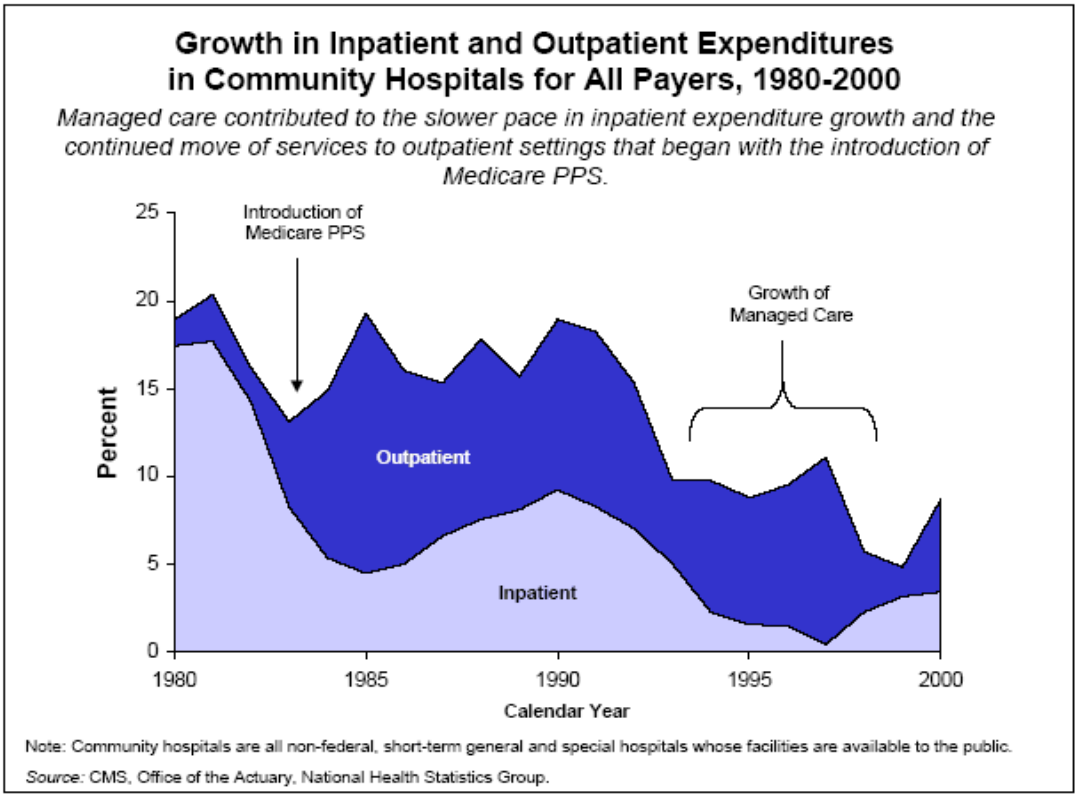
[20] CMS adjusted its treatment of outlier payments in 2003, in response to concerns about manipulation of the outlier payment adjustment by some hospitals. *See* CENTERS FOR MEDICARE & MEDICAID SERVICES, HEALTH CARE INDUSTRY MARKET UPDATE: ACUTE CARE HOSPITALS 11 (2003), *available at* http://www.cms.hhs.gov/reports/hcimu/hcimu_07142003.pdf.

[21] *See* II CENTERS FOR MEDICARE & MEDICAID SERVICES, HEALTH CARE INDUSTRY MARKET UPDATE: ACUTE CARE HOSPITALS, APPENDIX: MEDICARE PAYMENT SYSTEMS (2002), *available at* http://www.cms.hhs.gov/reports /hcimu/hcimu_04292002_append.pdf.

[22] Centers for Medicare & Medicaid Services, *The Home Health Prospective Payment System (PPS)*, *at* http://www.cms.hhs.gov/providers /hhapps/ (last modified June 3, 2004).

[23] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) instituted a phased-in competitive bidding program for durable medical equipment, prosthetics, and orthotics. CMS is required to establish competitive bidding in the 10 largest metropolitan statistical areas (MSAs) in 2007 and expand the

Figure 3:






The IPPS system was designed to control rising inpatient hospital costs and shift more care to the outpatient setting. The OPPS was designed to control rising outpatient costs. As Figure 3 reflects, both systems constrained costs more effectively than the cost-based systems they replaced.[24] Because the government establishes prices in the IPPS and OPPS, neither system adequately reflects the prices that would prevail in a competitive market.

As described in greater detail in Chapter 5, each state also has a Medicaid program, which pays for care provided to the poor and disabled.[25] Within broad guidelines established by Federal law, each state sets its own payment rate for Medicaid services and administers its own program. Medicaid programs either pay health care providers directly on a fee-for-service basis,

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program to the 80 largest MSAs in 2009. Prices negotiated in those areas may be applied nationwide. The legislation includes provisions to ensure quality, protect small suppliers, and mandate multiple winners.

[24] Figure provided by Centers for Medicare & Medicaid Services, *Program Information on Medicare, Medicaid, SCHIP, and Other Programs*, § 1, at 18 (June 2002), *at* http://www.cms.hhs.gov /charts/series/sec1.pdf.

[25] *See* U.S. Census Bureau, *Types of Health Insurance Coverage*, *at* http://www.census.gov/hhes /hlthins/hlthinstypes.html (last revised Apr. 21, 2004).

or use prepayment arrangements such as health maintenance organizations (HMOs). Many states have aggressively adopted prepayment arrangements for the Medicaid population.[26] As Chapter 5 details, there are other public payors.

### *B. Private Payors*

In some instances, private payors copied the reimbursement strategies of the Medicare program, or used Medicare DRGs as a reference price for negotiation.[27] Thus, some payors negotiate either a specified discount or a specified payment relative to the amount CMS would pay for a specified treatment episode. More often, private payors and hospitals negotiate discounts from charges (*e.g.*, they pay 85 percent of billed charges) or a per diem rate. Some contracts provide for a fixed payment for inpatient services on a per-case basis. Outpatient payment provisions are typically structured on a percentage-of-billed charges or fee-schedule basis.

## V. RISING HOSPITAL PRICES

Expenditures on hospital services have grown over the past two decades, but the rate of spending growth has varied. As noted previously, IPPS slowed the rate of hospital expenditure growth. The rise of managed care slowed the rate of expenditure growth further; from 1993 through 1998, hospital expenditures increased at an average annual rate of 3.7 percent and in some areas of the country, the per diem price of a hospital stay actually decreased.[28]

In the past five years, rising hospital prices have driven spending on hospitals higher, even though hospital utilization is declining.[29] Analysts attribute rising hospital prices to a

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[26] CENTERS FOR MEDICARE & MEDICAID SERVICES, STATE MEDICAID MANUAL, PART 2 – STATE ORGANIZATION AND GENERAL ADMINISTRATION §§ 2102(C), 2103(A), *at* http://www.cms.hhs.gov/manuals/45_smm/sm_02_2_2100_to_2106.2.asp; CENTERS FOR MEDICARE & MEDICAID SERVICES, 2002 MEDICAID MANAGED CARE ENROLLMENT REPORT (2002).

[27] *See, e.g.*, Shoptaw 4/11 at 61 (stating that in the Little Rock market, "[r]eimbursement, . . . is largely discounted with fee for service with DRGs and per diems . . . .").

[28] *See supra* Figure 3. *See also* Altman 2/28 at 13; Stuart H. Altman, *Testimony of Stuart H. Altman, Ph.D.* 4 (2/28) (1997 marked the fourth consecutive year for which the rate of spending growth for inpatient hospital use declined) [hereinafter Altman (stmt)], *at* http://www.ftc.gov/ogc /healthcarehearings/docs/altmanstuarth.pdf; Stuart H. Altman, *Testimony of Stuart H. Altman, Ph.D.* 3 Chart 2 (2/28) (slides), *at* http://www.ftc.gov/ogc /healthcarehearings/docs/altmanstuart2.pdf.

[29] *See* Bradley C. Strunk & Paul B. Ginsburg, *Tracking Health Care Costs: Trends Turn Downward in 2003*, 2004 HEALTH AFFAIRS (Web Exclusive) W354, 356-57 (spending on hospital inpatient care per privately insured person rose 6.5 percent; spending on hospital outpatient care per privately insured person rose 11 percent), *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.354v1.

*See also* William Brewbaker, *Overview of the Health Care Marketplace: Structural, Legal and Policy Issues* 8 (9/2/02) (slides), *at* http://www.ftc .gov/ogc/healthcare/brewbaker.pdf; Centers for Medicare & Medicaid Services, Office of the Actuary, *The Nation's Health Dollar: 2002* (reproducing charts entitled "Where It Came

variety of factors including "hospitals' increasing ability to negotiate higher prices from private payers."[30]

Two recent studies project spending on inpatient hospital services will continue to increase in the coming decade. CMS estimated that expenditures on inpatient care will grow at an average rate of 6.4 percent per year until 2005, and then grow at a slower rate of 5.6 percent through 2013.[31] Thus, spending on hospital care is estimated to total $934 billion in 2013, or a 55 percent real increase per capita.[32] These estimates are premised on the expectation that rising health care costs and a slowing economy will make employers and consumers more willing to accept restrictions on coverage. Similarly, another paper projected expenditures on hospital services will increase by 75 percent per capita.[33] Thus, experts predict spending on inpatient care will increase much faster than inflation in the coming decade.

## VI. PRESSURES ON HOSPITALS

Panelists listed a number of pressures facing hospitals. These pressures included increasing costs from the public's demand for the latest technology,[34] the aging of the population,[35] shortages of nursing staff and other hospital personnel (which have forced hospitals to increase salaries),[36] increased regulatory requirements,[37] payor demands for information,[38]

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From" and "Where It Went" from the Office of the Actuary, National Health Statistics Group), *at* http://www.cms .gov/statistics/nhe/historical/chart.asp (last modified Jan. 8, 2004).

[30] Levit, *supra* note 3, at 154-55. *See also* Strunk & Ginsburg, *supra* note 29, at W357 ("This trend is consistent with qualitative research, which has showed that many hospitals solidified their negotiating leverage over plans during 2002 and 2003 and continued to use their formidable power to demand large payment rate increases.").

[31] Heffler, *supra* at 7, at W4-90.

[32] *Id*. at W4-80.

[33] David Shactman et al., *Outlook for Hospital Spending*, 22 HEALTH AFFAIRS 12, 15 (Nov./Dec. 2003). The specific factors these authors identified were the resurgence of inpatient spending, rising outpatient care spending, increasing technology costs, stable inpatient lengths of stay, expectations of the baby-boom generation, and the increasing number of obese and overweight individuals.

[34] *See* Varney 2/27 at 201 ("[P]atients are being treated earlier with more aggressive and new, very expensive technologies …."); Andrew 3/26 at 15; Morehead 3/26 at 25. One panelist acknowledged the new and improved technology was an important factor in rising costs, but suggested that enhancements in the quality of care would ultimately result in lower payments to hospitals. R. Ryan 3/26 at 33-34.

[35] Sacks 3/26 at 41.

[36] *See, e.g*., Harrington 4/11 at 41-42, 44 (describing a recent increase of nurses' salaries by $7 million, as well as capital investments in nursing schools to increase enrollment); Kahn 2/27 at 71 (stating the primary driver, i.e., "the big banana," of hospital expenditures is compensation and benefits); Varney 2/27 at 201 ("[C]ontributing to falling margins is the skyrocketing growth of labor costs."); Strunk 3/27 at 160 (same); Argue 4/11 at 249-50 (same).

One New York hospital testified that approximately 15 percent of nursing positions at its facility are vacant

patient safety initiatives,[39] meeting homeland security requirements,[40] the rising cost of liability premiums[41] and prescription drugs,[42] and the obligation of providing care to the uninsured.[43] Hospital representatives also emphasized the impact of managed care and the cuts imposed by the Balanced Budget Act of 1997 on reimbursement.[44] Panelists asserted that these pressures

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and that radiology technicians are also in short supply. The shortages create a cycle of employees switching back and forth between competing institutions, with each move increasing the salary that is paid. *See* Andrew 3/26 at 10; Morehead 3/26 at 25 (an Ohio hospital system reporting a 30 percent raise for nurses over a three-year period); R. Ryan 3/26 at 29-30 (a Washington, DC hospital system noting a 20 to 30 percent vacancy rate of its permanent staff positions); Bates 4/11 at 87.

[37] Andrew 3/26 at 17.

[38] Charles N. Kahn, III, *Statement of the Federation of American Hospitals* 4-5 (5/29), *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030529charleskahn.pdf.

[39] Sacks 3/26 at 44.

[40] Harrington 4/11 at 43.

[41] Varney 2/27 at 202.

[42] Bates 4/11 at 86-87; Strunk 3/27 at 160; Argue 4/11 at 250.

[43] *See* Varney 2/27 at 202 (noting uncompensated care amounted to $21.5 billion in 2001); Kahn 2/27 at 72; Waxman 2/28 at 68; Mansfield 4/25 at 84 (describing how one hospital system had provided a total of $29 million of expenses for unreimbursed services for 112,000 persons).

In 2000, uninsured patients accounted for an average of 4.8 percent of all inpatient discharges, and 10.2 percent of emergency department discharges. Catherine G. McLaughlin & Karoline Mortensen, *Who Walks Through the Door? The Effect of the Uninsured on Hospital Use*, 22 HEALTH AFFAIRS 143, 150 (Nov./Dec. 2003). These averages do not reflect an equally shared burden; the percentage of the uninsured varies significantly from state to state, and at individual hospitals within those states. For example, in Little Rock, Arkansas, 13 percent of the people are uninsured; in Boston, Massachusetts, 6.1 percent of the people are without insurance. *See* K. Ryan 4/11 at 15-18; Allen 4/25 at 101; JOHN F. HOADLEY ET AL., CTR. FOR STUDYING HEALTH SYS. CHANGE, COMMUNITY REPORT NO. 12, HEALTH CARE MARKET STABILIZES, BUT RISING COSTS AND STATE BUDGET WOES LOOM IN BOSTON (2003), *at* http://www.hschange.org/CONTENT/611/. In at least one Southwestern state, the percentage of the uninsured is approximately 25 percent. *See* ROBERT J. MILLS & SHAILESH BHANDARI, U.S. DEP'T OF COMMERCE, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2002 (2003), *at* http://www.census.gov/prod/2003pubs/p60-223.pdf. Over the next five to ten years, uninsured inpatient stays are projected to increase by less than 1 percent, emergency department use by the uninsured is projected to increase 3.1 percent, and uninsured outpatient visits are expected to increase by approximately 2.3 percent. McLaughlin & Mortensen, *supra*, at 151-52.

[44] Kahn 2/27 at 70 (asserting that in the mid 1990s, "hospitals arguably underpriced their products to meet the demands of managed care contracts, . . . and significant Medicare reductions"); Altman 2/28 at 18-19; Altman (stmt), *supra* note 28, at 6 (between 1997 and 2000 hospital operating margins in the U.S. declined every year and by 2000 the operating margin was 2 percent; in Massachusetts the operating margin in 2000 averaged negative 1.4 percent); Fine 9/9/02 at 224 ("Hospitals have deferred and deferred acting on plant, but now we have a situation with the baby boomers coming through where demand for services far outstrips our ability to meet that demand.").

explained and justified recent hospital price increases.[45]

## VII. REORGANIZATION OF THE HOSPITAL SYSTEM

Over the past 20 years, hospitals have been consolidating into multi-hospital systems.[46] In 2001, almost 54 percent of hospitals operated as part of a system, with an additional 12.7 percent working in looser health networks. In 1979, only about 31 percent of hospitals were part of a system.[47] Consolidation presents an opportunity for hospitals to compete more efficiently. Consolidated hospitals can employ mechanisms to improve the quality of care and limit duplication of services or administrative expenses. Consolidated hospitals may also be able to improve quality if they centralize performance of complex procedures for which greater volume leads to higher quality. Consolidated hospitals could also use their combined resources to track established clinical quality measures and develop new ones.

Initially, national systems acquired hospitals throughout the United States, but recent acquisitions have been more localized.[48] For example, according to one panelist, St. Louis has

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[45] Sacks 3/26 at 43 (*e.g.*, in 2001 Advocate Health Care's operating margin was 2.59 percent; in 2002 it dropped to 1.8 percent "despite significant cost reductions and efficiencies, $20 million savings from our system-wide supply chain initiative, centralized information systems, administrative services that have taken real dollars in the tens of millions out of our expense structure"); Shelton 3/26 at 48 (even hospitals with a positive cash flow do not have enough cash to upgrade equipment, expand services, or meet the growing utilization needs of an aging population).

[46] DEBORAH HAAS-WILSON, MANAGED CARE AND MONOPOLY POWER: THE ANTITRUST CHALLENGE 28 (2003). *See also* Deborah Haas-Wilson & Martin Gaynor, *Increasing Consolidation in Healthcare Markets: What Are the Antitrust Policy Implications?*, 33 HEALTH SERVICES RES. 1403 (1998) ("Healthcare providers and insurers have been aligning in a plethora of coalitions as mergers, networks, joint ventures, and contracts have developed and dissolved with great rapidity. The implications of this reorganization for healthcare competition, and thus for costs, quality, and innovation, are profound. The key questions are to what extent these changes enhance efficiency and quality, and to what extent they facilitate collusion and market power."); MARTIN GAYNOR & DEBORAH HAAS-WILSON, CHANGE, CONSOLIDATION AND COMPETITION IN HEALTH CARE MARKETS 19 (Nat'l Bureau of Econ. Research, Working Paper No. 6701, 1998) ("The most extensive research evidence on competitive conduct by firms in health care markets is on hospitals; Dranove and White (1994) offer an extensive survey. These studies use differing product and geographic market definitions and research methods, yet the consistency of the results is striking. Increased concentration is associated with increased prices in markets for hospital services."), *available at* http://papers.nber.org/papers/w6701.pdf; David L. Redfern, *Competition in Healthcare Workshop (Oct. 8, 2003)* (Public Comment).

[47] Bazzoli 5/29 at 12; Gloria J. Bazzoli, *The US Hospital Industry: Two Decades of Organizational Change?* 7 (5/29) (slides) (same) [hereinafter Bazzoli Presentation], *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030529bazzoli.pdf. Not all mergers or consolidation into systems have gone smoothly. *See* Waxman 2/28 at 64 (noting that the CareGroup system "merger has not been stellar. Cultures clashed; strong central leadership was not established; and over a period of several years large amounts of money were lost.").

[48] David Dranove & Richard Lindrooth, *Hospital Consolidation and Costs: Another Look at the Evidence*, 22 J. HEALTH ECON. 983, 984 (2003); Alison Evans Cuellar & Paul J. Gertler, *Trends in Hospital Consolidation: The Formation of Local Systems*, 22 HEALTH AFFAIRS 77, 80 (Nov./Dec. 2003).

31 hospitals. Four of those hospitals are independent; the remaining hospitals have joined one of four local systems.[49] Similarly, one academic described the consolidation in San Francisco: by 1999 "almost all hospitals … became part of one of four not-for-profit hospital systems."[50] Another panelist described the Boston metropolitan area consolidation as being one where "through mergers and acquisitions … the PCHI [Partners Community HealthCare Inc.] network now numbers 15 hospitals and more than 5,000 physicians."[51] One study noted dramatic consolidation in numerous communities, including Cleveland, "where two local hospital systems now control nearly 70 percent of the area's inpatient capacity," and Indianapolis and Phoenix, where "hospitals have carved out strongholds in key urban and suburban areas, at times creating virtual monopolies in geographic submarkets."[52]

Hospitals may consolidate within a single market or across markets, and consolidation can occur over a broad spectrum of possibilities.[53] At one end of the spectrum, consolidating hospitals have a shared license and common ownership, report unified financial records, and eliminate duplicative facilities.[54] At the other end of the spectrum, a common governing body

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[49] Probst 5/29 at 84; Louise Probst, *Hearing on Hospital Market Competition* 3 (5/29) (slides), *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030529probst.pdf; Scicchitano 3/27 at 182-83 (describing the Long Island hospital environment as having "25 hospitals in Nassau and Suffolk [counties], with 21 of them grouped into three health systems").

[50] HAAS-WILSON, *supra* note 46, at 28. *See also* Joanne Spetz et al., *The Growth of Multihospital Firms in California*, 19 HEALTH AFFAIRS 224, 225 (Nov./Dec. 2000) (Study of the California hospital industry revealed at least half of all hospitals are affiliated with multisite systems; by 1996, 83 percent of Sacramento's hospitals beds were held by three hospital systems and in San Francisco three hospital systems control 43 percent of the region's hospital beds.).

[51] *See* Berman 2/28 at 80.

[52] CARA S. LESSER & PAUL B. GINSBURG, BACK TO THE FUTURE? NEW COST AND ACCESS CHALLENGES EMERGE (Ctr. for Studying Health Sys. Change, Issue Brief No. 35, 2001), *available at* http://www.hschange.org/CONTENT/295/. Not all systems have succeeded. Some deals have come apart because of discrepancies over control and differences in mission and some deals have met problems because the systems' financial performance was strained by assuming the debt load and excess capacity of financially weak hospitals. *See* CARA S. LESSER ET AL., CENTER FOR STUDYING HEALTH SYSTEM CHANGE, COMMUNITY REPORT NO. 12, CONSOLIDATION CONTINUES, FINANCIAL PRESSURES MOUNT: NORTHERN NEW JERSEY (1999), *at* http://www.hschange.org/CONTENT/108/.

[53] "Within market" consolidation is the merger of two hospitals within the same product and geographic market. "Across market" consolidation is the joining of hospitals producing similar services in different geographic and/or product markets.

[54] *See* Cuellar & Gertler, *supra* note 48, at 77; Dranove & Lindrooth, *supra* note 48, at 984; Patricia Cameron, *Personal Views of Patricia Cameron* 1 (Public Comment) (stating that "[w]hen two hospitals in one market area . . . merge, and consolidate services that were otherwise duplicative (including management, overhead and advertising), it appears that patients and physicians have benefitted"); K. Smith 4/11 at 174-75 (stating that one hospital system, as a result of its consolidation efforts, had "eliminated almost all duplicative overhead and patient care services that our system had" and created "a single medical record for all three hospitals" that is also "shared electronically amongst all physicians").

owns the consolidating hospitals, but the hospitals maintain separate hospital facilities, retain their individual business licenses, and keep separate financial records.

Hospital systems have varying degrees of centralized control. One panelist noted that some systems have a parent organization that sets policy and makes key decisions. At the other extreme, the same panelist noted that some systems offer little more than centralized administrative oversight and capital financing.[55] Another panelist noted that "the various hospital mergers that were particularly frequent in the mid-1990s tended not to follow through when it came to clinical integration …."[56]

Panelists identified several reasons for hospital consolidation, including the reduction of excess capacity, the rise of managed care, increased ability to assume capitated financial risk, expansion of the hospital's delivery network, and service consolidation and coordination.[57] Analysts have also suggested other factors that might be driving consolidation, including the desire to obtain economies of scale in purchasing or production, access to capital markets, and "specialization in labor or management techniques."[58]

Some panelists assert hospital consolidation has promoted efficiency, led to savings, and instilled life back into failing hospitals.[59] Other panelists believe the primary result of

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[55] *See* Bazzoli 5/29 at 18-19; Bazzoli Presentation, *supra* note 47, at 16.

[56] Ginsburg 2/26 at 61-62. *See also* C. Baker 2/28 at 42 (alleging that in Massachusetts "the hospitals that made up [one] care delivery system continued to operate on a stand-alone basis with little clinical or systems integration");Vincent Scicchitano, *Contracting Practices* 6-8 (3/27), *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030327vincentscicchitano.pdf.

[57] Ginsburg 2/26 at 62-63 (as hospitals "were pressed to cut their costs, they had motivation to take excess capacity out of the system"); Varney 2/27 at 215 (noting that in some areas with multiple hospitals, each was operating "at 20, 30, 40 and in the best cases, 60 percent capacity"); Eugene Anthony Fay, *Statement of the Federation of American Hospitals – Hospital's Non-Profit Status* 4 (4/10) ("Consolidation of operations brings efficiencies and cost savings to the systems."), *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030410fay.pdf; Fay 4/10 at 27 (same). The cost of excess capacity can be daunting. One study found that an empty bed cost $48,826 in 1995 dollars. Martin Gaynor & Gerard F. Anderson, *Uncertain Demand, the Structure of Hospital Costs and the Cost of Empty Hospital Beds*, 14 J. HEALTH ECON. 291 (1995). *See also* Morehead 3/26 at 20-22 (one panelist noting one of the ways that its hospital system has addressed the shift from inpatient to outpatient focus is to create a regional network that includes large and small hospitals, as well as ambulatory care centers); Lawton R. Burns & Mark V. Pauly, *Integrated Delivery Networks: A Detour on the Road to Integrated Health Care?*, 21 HEALTH AFFAIRS 128, 129 (July/Aug. 2002).

[58] Timothy S. Snail & James C. Robinson, *Organizational Diversification in the American Hospital*, 19 ANN. REV. PUB. HEALTH 417, 419 (1998). Empirical studies have shown, however, that economies of scale in the production of hospital inpatient services primarily occur in the 200 to 400 bed range. *Id*. at 435. *See also* Spetz et al., *supra* note 50, at 226.

[59] *See, e.g.*, Welch 2/28 at 112-113; F. Miller 2/28 at 92; Mongan 2/28 at 32-33. *But see* Greaney 2/27 at 237 (noting "there are a number of studies that question whether efficiencies – promised efficiencies – were realized").

consolidation has been the creation of hospital market power against payors.[60] One study examining consolidation through mergers found that hospitals that merged tended to be in less-concentrated markets and in areas with higher HMO penetration.[61] Merging hospitals were also more likely to have been a member of a system, were larger, had higher occupancy rates and case-mix indexes, and higher pre-merger expenses and revenues.[62]

One recent review examined the operational consequences of hospital consolidation.[63] It found that when hospitals that consolidated were geographically distant, they generally had similar staffing ratios, similar occupancy rates, and substantial service duplication. For these distant hospitals, typically both were financially viable. Duplicative acute care services were generally not eliminated, unless one of the hospitals was more specialized, was economically weaker or had different staffing levels, or there existed a substantial degree of competition between the merging hospitals.[64] One recent study indicated that when systems acquired hospitals, efficiencies did not materialize, because of the failure to combine operations.[65]

Most studies of the relationship between competition and hospital prices generally find increased hospital concentration is associated with increased prices.[66] One study found that merged hospitals experience larger price and cost increases than those that have not merged,

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[60] *See, e.g.*, Berman 2/28 at 80-81, 83; Desmarais 2/27 at 168; Washington Business Group on Health, *Comments Regarding Competition Law and Policy & Health Care (Sept. 30, 2002)* (Public Comment).

[61] Robert A. Connor et al., *Which Types of Hospital Mergers Save Consumers Money?*, 16 HEALTH AFFAIRS 62, 65 (Nov./Dec. 1997) (The data set includes 122 within-market-area horizontal hospital sets; merger is defined as two or more similar corporations coming together into a single surviving entity).

[62] Connor et al., *supra* note 61, at 71.

[63] Snail & Robinson, *supra* note 58, at 434-35.

[64] *Id*. *See also* DAVID DRANOVE, THE ECONOMIC EVOLUTION OF AMERICAN HEALTH CARE 122 (2000) ("I have asked many providers why they wanted to merge. Although publicly they all invoked the synergies mantra, virtually everyone stated privately that the main reason for merging was to avoid competition and/or obtain market power.").

[65] Dranove & Lindrooth, *supra* note 48, at 996.

[66] David Dranove et al., *Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payer-Driven Competition*, 36 J.L. & ECON. 179, 201 (1993) (finding that market concentration in California led to rate increases); Glenn A. Melnick et al., *The Effect of Market Structure and Bargaining Position on Hospital Prices*, 11 J. HEALTH ECON. 217 (1992) (finding market concentration appears to increase hospitals' bargaining power with insurers and self-insurers); Ranjan Krishnan, *Market Restructuring and Pricing in the Hospital Industry*, 20 J. HEALTH ECON. 213, 215 (2001) (mergers that increase hospital market share in specific hospital services, as measured 33 DRGs, show a corresponding increase in prices of those services). *But see* Charles N. Kahn, III, *Statement of the Federation of American Hospitals* 2 (2/27) (questioning the validity of various studies of cost increases as related to consolidation), *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030227kahniii.pdf.

except in less concentrated areas where these patterns were reversed.[67] Another study using similar data and methods found that merger cost and price savings were lower than the first study when merging hospitals were compared against rival institutions.[68] One set of commentators has observed that most empirical studies on concentration and consolidation do not differentiate among transactions that occur within markets and those that occur across markets, even though these transactions "might reflect very different hospital strategies and consequently, could have different effects on efficiency."[69]

According to several panelists, hospital systems try to make sure they have at least one "must have" hospital in each geographic market in which they compete.[70] A "must have" hospital or hospital system is one that health care plans believe they must offer to their beneficiaries to attract employers to their plan. According to some panelists, this status allows the hospital or hospital system to demand price increases.[71]

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[67] Connor et al., *supra* note 61, at 68.

[68] Heather Radach Spang et al., *Hospital Mergers And Savings for Consumers: Exploring New Evidence*, 20 HEALTH AFFAIRS 150, 156 (July/Aug. 2001). The changes included removing rural hospitals from the sample, excluding hospitals that are part of hospital systems from the "nonmerging" group, and separating nonmerging hospitals into nonmerging rival hospitals and nonmerging nonrival hospitals. *But see* Guerin-Calvert 4/10 at 209 ("And I think again in general, what the studies show is that some mergers do result in price increases that can't be explained by cost increases but that overall the patterns that we see is actually pricing increasing at a slower rate than cost increases.").

[69] *See* Cuellar & Gertler, *supra* note 48, at 77; Snail & Robinson, *supra* note 58, at 440.

[70] *See, e.g.*, Berman 2/28 at 80-81 (hospitals "have planned these mergers and affiliations strategically to include anchor community hospitals"); Charles D. Baker, *Testimony of Charles Baker* 9 (2/28) (Brigham and Massachusetts General "are probably the two best-known tertiary hospitals in New England and they contract together …. The fact that they represent only two of many teaching hospitals in Massachusetts doesn't really matter. For certain kinds of services, they are virtually the only choice around.") [hereinafter C. Baker (stmt)], *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030228baker.pdf; C. Baker 2/28 at 46-48 (same); Probst 5/29 at 85 ("[T]here's one hospital in one of the systems that, for different reasons, by many consumers, is seen is a must-have hospital, which makes it a little bit tougher, but really, every one of the systems has a must-have hospital for a given employer or a given, you know, consumer population, and all the systems require – it's all or nothing."); Scicchitano 3/27 at 183-84; Strunk 3/27 at 157-58.

[71] *See, e.g.*, Berman 2/28 at 81-82 (Hospital systems that own "virtually every hospital" in an MSA aggregate power that makes them "literally … a must-have hospital system for area employers and consumers." Hospital systems then "use[] this position to demand price increases …."); C. Baker (stmt), *supra* note 70, at 7 (consumer and employer preferences make it very difficult for health plans to discontinue their relationship with any hospital in its service delivery area); C. Baker 2/28 at 46-47; C. Baker (stmt), *supra* note 70, at 8 (Harvard Pilgrim Health Care members pay more today for services from hospital systems than if each hospital contracted individually). *See also* Zwanziger 3/26 at 95 ("[I]n every market that we looked at, where there is a tertiary center, then every plan, without exception, had at least one tertiary center in their network …. I suspect that that's because they really regard having one tertiary center at least is an important part of their ability to compete effectively."); Jack Zwanziger, *Defining Hospital Markets* 5 (3/26) (slides) (same), *at* http://www.ftc.gov/ogc/healthcarehearings/docs /zwanziger.pdf; Fred Dodson, *Health Insurance Monopoly Issues – Competitive Effects* 7-8 (4/23) (noting that provider systems impact insurance product offerings, when systems

Consolidation has resulted in complaints by payors about the exercise of market power by hospitals.[72] Some panelists and commentators believe an important motivation for the creation of multi-hospital systems has been to gain market power to secure higher reimbursement from payors.[73] One panelist stated the various hospital mergers occurring in the mid-1990s "tended not to follow through when it came to clinical integration and ultimately providers have regained the leverage with health plans that they had lost."[74] Another study examined the relationship between market power and pricing in nonprofit, multi-hospital systems. The investigation led to two primary findings: (1) nonprofit hospitals that were members of national or regional systems appear to have priced their services "more aggressively in the presence of market power" than the hospitals did when operating independently or as members of local systems; and (2) nonprofit systems showed a tendency to exercise market power in the form of higher prices.[75]

The rise of hospital systems has affected market concentration in certain markets. One study found that if hospital system members within metropolitan statistical areas (MSA) are

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refuse to participate in tiering), *at* http://www.ftc.gov/ogc /healthcarehearings/docs/030423freddodson.pdf.

[72] As one pair of analysts noted, however, "traditional economic theory says that a monopolist firm in one market cannot leverage monopoly power in a separate, competitive market, which makes it difficult from the standpoint of market power to understand why some hospital systems" are national. Cuellar & Gertler, *supra* note 48, at 84. They further note that more recent theories focusing on the nature of bargaining between managed care firms and providers may leave room to challenge this theory. *Id. See also* David Dranove & William D. White, *Emerging Issues in the Antitrust Definition of Healthcare Markets*, 7 HEALTH ECON. 167 (1998).

[73] Spetz et al., *supra* note 50, at 226. *See also* Kanwit 2/27 at 98 ("[H]ospital consolidation is causing a rise in health care costs and affecting … the health plans' ability to contract cost effective care …."); American Ass'n of Health Plans, *Additional Talking Points in Response to AHA's Study on Hospital Costs* (Public Comment); Kahn 2/27 at 111 (stating that consolidation has not been prevalent across the country, but also noting that "hospitals reduced their sizes in response to constraints for managed care, in response to Medicare cutbacks, and now that there are less beds and, in a sense, [hospitals have] more market power in negotiating with payors"); Binford 9/24 at 131 (noting "the advent of hospital networks and the acquisition of many heretofore independent and competing physician practices, [] has enabled hospitals to really control the negotiating process of not only their own contracts, but physician contracts"); Langenfeld 4/11 at 192 (noting his observation that "[p]re-merger, perhaps the acquired hospital has lower rates to private payors than the acquiring hospital has. After the merger, the acquiring hospital raises the rates up to its higher level, which on average is a price increase. And I have also observed that these rate increases can be as much as 50 percent, or sometimes even more."); Greaney 2/27 at 136-37 (same). *But see* MARGARET E. GUERIN-CALVERT ET AL., ECONOMIC ANALYSIS OF HEALTHCARE COST STUDIES COMMISSIONED BY BLUE CROSS BLUE SHIELD ASSOCIATION (2003) (finding hospital merger activity does not explain the increases in spending for hospital services), *at* http://www.hospitalconnect.com/aha/press_room-info/content/EconomistReport030225.pdf.

[74] Ginsburg 2/26 at 61-62.

[75] Gary J. Young et al., *Community Control and Pricing Patterns of Nonprofit Hospitals: An Antitrust Analysis*, 25 J. HEALTH POL., POL'Y & L. 1051, 1073 (2000).

treated as one entity, nineteen MSAs became concentrated between 1995 and 2000.[76] Seven of the 19 MSAs showed an increase in HHI of at least 1,700.

As discussed in Chapter 4, the Agencies will continue to evaluate hospital consolidation to determine whether consolidation (or potential consolidation) in any given market is anticompetitive.[77]

## VIII. ENTRY OF SPECIALTY HOSPITALS AND AMBULATORY SURGERY CENTERS

Specialty hospitals provide care for a specific specialty (*e.g.*, cardiac, orthopedic, or psychiatric) or type of patient (*e.g.*, children or women).[78] Specialty hospitals tailor their care and facilities to fit the chosen type of condition, patient, or procedure on which they focus. Specialty hospitals are not new to the hospital industry. Pediatric and psychiatric hospitals have existed for decades. More recently, numerous cardiac and orthopedic surgery hospitals have opened or are under construction. These single-specialty hospitals (SSHs) differ from their predecessors in that many of the physicians who refer patients have an ownership interest in the facility.[79] SSHs may compete with both inpatient and outpatient general hospital surgery departments as well as with ambulatory surgery centers.

There are relatively few SSHs. In October 2003, the General Accounting Office

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[76] Cuellar & Gertler, *supra* note 48, at 82. The study used a change in the Herfindahl-Hirschmann Index (HHI) of 1,700 as the benchmark for determining whether a market became highly concentrated.

[77] The Commission recently challenged a consummated merger between Evanston Northwestern Healthcare Corporation and Highland Park Hospital. *In re* Evanston Northwestern Healthcare Corp., No. 9315 (Feb. 10, 2004) (complaint), *at* http://www.ftc.gov/os/caselist /0110234/040210emhcomplaint.pdf. Moreover, the Commission's Bureaus of Economics and Competition are evaluating the effects of consummated hospital mergers in several cities. The Commission will announce the results of these retrospective studies as they are completed. The Commission announced on June 30, 2004 that it had closed an investigation into the acquisition of Provena St. Therese Medical Center by Vista Health Acquisition. *See* Press Release, Federal Trade Comm'n, FTC Close Investigation Into Merger of Victory Memorial Hospital and Provena St. Therese Medical Center (July 1, 2004) and related documents at http://www.ftc.gov/opa/2004/07/waukegan.htm.

[78] G. Lynn 3/27 at 27 ("Historically, they were children's hospitals or psych. hospitals; now they include heart hospitals, cancer hospitals, ambulatory surgery centers, dialysis clinics, pain centers, imaging centers, mammography centers and a host of other narrowly focused providers generally owned, at least in part, by the physicians who refer patients to them.").

[79] Lesser 3/27 at 9-10 (A "key characteristic of the specialty hospitals is physician ownership, and this is something that really distinguishes the speciality hospitals of today from the traditional acute care hospitals and from some of the children's hospitals and other single-specialty hospitals that we've seen in the past.").

As Chapter 1 notes, the Self-Referral Amendments limit the ability of providers to receive payment from Medicare for designated health services delivered when the provider refers a consumer to a facility in which the provider has an ownership or investment interest. Investment in a "whole hospital," however, is not considered a designated health service under the Self-Referral Amendments.

identified 100 existing SSHs with an additional 26 under development. SSHs are located in 28 states, but two-thirds are located in only seven states.[80] The GAO concluded that "the location of specialty hospitals is strongly correlated to whether states allow hospitals to add beds or build new facilities without first obtaining state approval for such health care capacity increases."[81] Ninety-six percent of the opened SSHs and all 26 SSHs under development are located in such states.[82] The recently imposed moratorium on Medicare payments to SSHs, and the results of two Congressionally mandated studies on the industry are likely to affect the future development of these hospitals.[83] Under the moratorium, physicians may not refer Medicare patients to a specialty hospital in which they have an ownership interest, and Medicare may not pay specialty hospitals for any services rendered as a result of a prohibited referral.[84]

Panelists identified a number of market developments that encouraged the emergence of

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[80] U. S. GENERAL ACCOUNTING OFFICE, GAO-04-167, SPECIALTY HOSPITALS: GEOGRAPHIC LOCATIONS, SERVICES PROVIDED AND FINANCIAL PERFORMANCE 3-4 (2003) (Report to Congressional Requesters) [hereinafter GAO, SPECIALTY HOSPITALS], *at* http://www.gao.gov/new.items /d04167.pdf. The seven states are Arizona, California, Texas, Oklahoma, South Dakota, Louisiana, and Kansas. Of those seven states, only three (Texas, Oklahoma and Arizona) require all hospitals to have an emergency room. *Id.*

[81] GAO, SPECIALTY HOSPITALS, *supra* note 80, at 15. *See also infra* Chapter 8 (discussing Certificate of Need programs).

[82] GAO, SPECIALTY HOSPITALS, *supra* note 80, at 15. According to the GAO report, as of 2002, "37 states maintained certificate of need (CON) requirements to varying degrees. Overall, 83 percent of all specialty hospitals, 55 percent of general hospitals, and 50 percent of the U.S. population are located in states without CON requirements." *Id*. *See also* Lawrence P. Casalino et al., *Focused Factories? Physician-Owned Specialty Facilities*, 22 HEALTH AFFAIRS 56, 58-59 (Nov./Dec. 2003).

[83] Under the MMA, the Medicare Payment Advisory Commission (MedPAC) is required to study the differences in costs between specialty hospitals and community hospitals, the selection of patients, the financial impact specialty hospitals have on community hospitals, and the proportions of payment between specialty hospitals and community hospitals. HHS will study the referral patterns of the physicians with an ownership interest in specialty hospitals, the quality of care provided, and the provision of uncompensated care. Congress has placed a moratorium on Medicare payments to any new specialty hospital while the studies are ongoing. Congress has given the two agencies 15 months from the date of enactment to complete the studies. MMA § 507(C)(1)-(2).

CMS issued guidance for exceptions to the specialty hospital moratorium. *See* CENTERS FOR MEDICARE & MEDICAID SERVICES, U.S. DEP'T OF HEALTH & HUMAN SERVICES, CMS MANUAL SYSTEM, PUB. 100-20 ONE-TIME NOTIFICATION: CHANGE REQUEST 3036 (Mar. 19, 2004), *at* http://www.cms.hhs.gov/manuals/pm_trans/R62OTN.pdf; CENTERS FOR MEDICARE & MEDICAID SERVICES, U.S. DEP'T OF HEALTH & HUMAN SERVICES, MANUAL SYSTEM, PUB. 100-20 ONE-TIME NOTIFICATION: CHANGE REQUEST 3193 (May 7, 2004), *at* http://www.cms.hhs.gov/manuals/pm_trans /R79OTN.pdf. At least one forthcoming surgical hospital, offering heart and surgical care, claims it will not fall within Congress's definition of a specialty hospital because it will offer other services, including thoracic treatment and ear, nose and throat ailments as well as an emergency room with one bed and one procedure room. *See* Hugo Martin, *Group Plans Hospital in Loma Linda*, L. A. TIMES, Apr. 26, 2004, *at* http://www.latimes.com/news/local/state /la-me-hospital26apr26,1,6653902.story?coll=la-news-state.

[84] MMA § 507.

SSHs, including: less tightly managed care;[85] the willingness of providers to invest in a SSH;[86] physicians' desire to "provide better, more timely patient care";[87] physicians looking for ways to supplement declining professional fees;[88] and the growth of entrepreneurial firms, such as MedCath and National Surgical Hospitals.[89] Panelists also stated that some providers desire greater control over management decisions that affect their incomes and productivity.[90] Several panelists suggested efficiency was an important consideration for many providers: specialty hospitals allow "surgeons to start on time, do more cases in a given amount of time, and get back to their office on time."[91] One panelist asserted that physicians view SSHs as a "a blank slate" and an "opportunity to make improvements in the care delivery process" by "redesign[ing] the care delivery process in a way to be more effective and efficient."[92]

Several panelists contended that SSHs achieve better outcomes through increased

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[85] Lesser 3/27 at 10-11.

[86] *Id*. at 10-11.

[87] Alexander 3/27 at 34. *See also* Nat'l Surgical Hospitals, *Single Specialty Hospitals (Mar. 27, 2003)* (Public Comment).

[88] J. Wilson 4/11 at 66 (noting that as doctors make less money from insurance companies, they will "get into buying MRI machines, [] get into surgery centers … What [doctors are] doing is we're getting into ancillary activities in order to maintain our standard of income and living").

[89] Lesser 3/27 at 10-11.

[90] *See, e.g.*, D. Kelly 3/27 at 70 ("[I]t's because of the care, the control we have over the care provided for their patients in the in-patient setting; the empowerment within the hospital to help govern and set up the operating standards …."); Kane 4/11 at 74 (stating that many physicians are not looking to increase their declining income, rather they are starting specialty hospitals because they are dissatisfied with general hospitals "because of the inability to manage their day-to-day patient interactions and their inability to provide high-quality medical care"); Dan Caldwell, *Health Care Competition Law and Policy Hearings* 2 (Public Comment) (listing physicians participation in the governance of a facility and physician efficiency as influencing the development of SSH).

[91] Rex-Waller 3/27 at 51. *See also* Rex-Waller 3/27 at 50 (specialty hospitals are responding to a "demand born out of frustration with local acute care hospital management that is unresponsive" to surgeon and patient requirements). *See also* D. Kelly 3/27 at 70 (describing "the productivity enhancement it provides to them because all of them are getting busier and they need to find ways to be more productive"); D. Kelly 3/27 at 81 (noting the savings on expenses: "instead of spending 40 to 60 percent of your total operating expense on labor, which is typical in the United States in a fully integrated health system, we do that at around 30 percent on a fully allocated basis"); Alexander 3/27 at 35 (stating that operating rooms in some markets "are at capacity" and it is very difficult for physicians to schedule elective surgeries at general hospitals).

[92] Lesser 3/27 at 14. *See also* Alexander 3/27 at 33 ("Specialized facilities are a natural progression and are a recognition that the system needs to be tweaked, perhaps overhauled, to achieve lower costs, higher patient satisfaction, and improved outcomes.").

volume, better disease management, and better clinical standards.[93] They attribute these positive outcomes to their focus on a single specialty.[94] For example, MedCath stated that its focus has allowed it to increase access to cardiac monitored beds, "improve access to emergency services," "improve clinical outcomes" and lower the cost of care by having shorter hospital stays, discharging a higher percentage of patients directly home, and using the nursing labor pool efficiently.[95]

A panelist representing MedCath presented a study showing that 90 percent of its patients were discharged directly to home, compared to "72 percent for the peer community hospitals and 70 percent for the teaching facilities."[96] According to this panelist, for each early discharge, MedCath hospitals saved "Medicare over $1,000 per discharge."[97] Other panelists stated that physician-investors send healthier, lower-risk patients to the SSH and sicker patients to the general hospital.[98] Several panelists argued that this allows SSHs "to produce service less expensively, while often being paid the same or more than community hospitals."[99] An April, 2003 GAO report found that patients at specialty hospitals tended to be less sick than patients

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[93] Lesser 3/27 at 14-15 (noting that specialty hospitals across the country have stated that by "concentrating more cases in a particular facility, specialty hospitals may help to lower per-case costs and boost quality"). *See also* NEWT GINGRICH ET AL., SAVING LIVES AND SAVING MONEY (2003); REGINA HERZLINGER, MARKET DRIVEN HEALTH CARE: WHO WINS, WHO LOSES IN THE TRANSFORMATION OF AMERICA'S LARGEST SERVICE INDUSTRY (1997).

[94] Numerous empirical studies indicate that there is a relationship between the number of particular procedures performed and the probability of a good outcome. Harold S. Luft et al., *Should Operations Be Regionalized? The Empirical Relation Between Surgical Volume and Mortality*, 301 N. ENG. J. MED. 1364 (1979); John D. Birkmeyer, *Hospital Volume and Surgical Mortality in the United States*, 346 N. ENG. J. MED. 1128 (2002); Colin B. Begg, *Impact of Hospital Volume on Operative Mortality for Major Cancer Surgery*, 280 JAMA 1747 (1998).

[95] D. Kelly 3/27 at 72.

[96] *Id*. at 74. *See also* Dennis I. Kelly, *Federal Trade Commission and Department of Justice Hearings on Health Care and Competition Law and Policy* 10 (3/27) (slides) (average length of stay for MedCath patient 3.84 days compared against peer community hospital stay of 4.74 days; average mortality rate for MedCath patient 1.94 percent compared against peer community hospital rate of 2.35 percent; case mix index for MedCath patient is 1.42 compared against peer community hospital 1.17 case mix index), *at* http://www.ftc.gov/ogc /healthcarehearings/docs/dkelly.pdf.

[97] D. Kelly 3/27 at 74.

[98] *See, e.g.*, G. Lynn 3/27 at 30 (Specialty providers decisions about whether and where to provide care "have an effect on the physicians personal financial interest."); Mulholland 3/27 at 60 ("Physician ownership interests influence referrals. That's almost intuitive and there have been some studies that suggest that utilization increases.").

[99] G. Lynn 3/27 at 28. One panelist disputed the claim that physicians send sicker patients to general hospitals, stating that they want their "sick patients in the heart hospital [where] I can take care of them better." Kane 4/11 at 80.

with the same diagnoses at general hospitals.[100]

Similarly, several panelists noted that some SSHs do not provide emergency departments and thus avoid the higher costs of trauma treatment and indigent care.[101] Those panelists believe this gives SSHs an unfair competitive advantage over 24-hour hospitals with emergency departments.[102] The October 2003 GAO study analyzed whether SSHs provided care to Medicare and Medicaid patients and had emergency departments. As Table 1 shows, the study found that there were modest differences between the percentage of Medicare and Medicaid patients who received treatment at general hospitals and SSHs.[103]

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[100] Letter from A. Bruce Steinwald, Director, Health Care-Economic and Payment Issues, General Accounting Office, to Bill Thomas, Chairman, Committee of Ways and Means, House of Representatives & Jerry Kleczka, House of Representatives 11-12 (Apr. 18, 2003) (GAO-03-683R), *at* http://www.gao.gov/new.items/d03683r.pdf. The GAO examined all inpatient discharge data from 25 urban specialty hospitals and found that 21 of the 25 treated lower proportions of severely ill patients than did area general hospitals. *Id.* at 4.

[101] As Chapter 1 explains, if a SSH does not have an emergency department or offer emergency medical services, it is not required by the Emergency Medical Treatment and Labor Act to provide an appropriate medical screening examination to any individual that requests one, and stabilizing treatment to individuals with emergency medical conditions.

[102] *See, e.g.*, G. Lynn 3/27 at 29; George Lynn, *Perspectives on Competition Policy and the Health Care Marketplace: Single Specialty Hospitals* 2 (3/27), *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030327georgeflynn.pdf; Lesser 3/27 at 10-11; Cara Lesser, *Specialty Hospitals: Market Impact and Policy Implications* 6 (3/27) (slides) (considerable variation in scope of emergency services provided) [hereinafter Lesser Presentation], *at* http://www.ftc.gov/ogc /healthcarehearings/docs/lesser.pdf; Dan Mulholland, *Competition Between Single-Specialty Hospitals and Full-Service Hospitals: Level Playing Field or Unfair Competition?* 3 (3/27) (slides) [hereinafter Mulholland Presentation], *at* http://www.ftc.gov/ogc/healthcarehearings/docs/mulholland.pdf. *See also* GAO, SPECIALTY HOSPITALS, *supra* note 80, at 4, 22.

[103] GAO, SPECIALTY HOSPITALS, *supra* note 80, at 18. There were larger differences in the frequency of emergency departments (ED) at SSHs and general hospitals. In particular, 92 percent of general hospitals had an ED, but by contrast 72 percent of cardiac hospitals, 50 percent of women's hospitals, 39 percent of surgical hospitals, and 33 percent of orthopedic hospitals had an ED. *Id*.

**Table 1:**

| | General Hospitals | Specialty Hospitals |
|---|---|---|
| Orthopedic Medicaid Admissions | 10 % | 8% |
| Cardiac Care Medicaid Admissions | 6% | 3% |
| Medicaid Admissions for Women's Health | 37% | 28% |

One panelist observed that general hospitals are reluctant to have their performance compared to specialty providers who do not handle the same case mix or have the same cost structures.[104] Some panelists argued that the SSHs and ambulatory surgery centers are inherently risky for patients with multiple conditions. They argued that chronic disease management, rather than fragmented specialty services, will serve those patients better.[105]

Several panelists were concerned that SSHs would siphon off the most profitable procedures and patients, leaving general hospitals with less money to cross subsidize other socially valuable, but less profitable, care.[106] As one panelist stated, "it is the profitable services they are taking away that jeopardizes a hospital's capability of providing unprofitable services."[107] Panelists expressed concern that "the community [will] lose[] access to specific services or ultimately to all hospital services as the general hospital deteriorates or closes."[108] Several panelists also suggested that physicians that have an ownership interest in a SSH have an

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[104] Probst 5/29 at 95.

[105] Andrew 3/26 at 12 (Hospitals believe that the single-specialty hospitals do not take the more difficult cases with comorbidities, "with patients with greater acuity," "the frailest of the frail, and the poorest of the poor.").

[106] Lesser 3/27 at 14-21; Lesser Presentation, *supra* note 102, at 14-15; Ginsburg 2/26 at 66 (stating the "threat for specialized services does have the potential to erode some of the traditional cross subsidies that the health system is run on"); Lesser 9/9/02 at 92. *See also* G. Lynn 3/27 at 31 (arguing that the Agencies must take into account the effect specialty hospitals have on "the medical safety net" of the community hospital).

[107] Morehead 3/27 at 42. *See also* Harrington 4/11 at 76-77 ("We can't afford to continue to lose a percentage of our volume and thus our revenue, and be able to provide the same quality level of service that we provide … if we continue to be niched away."); G. Lynn 3/27 at 28 (specialty hospitals "threaten[] community access to basic health services and jeopardizes patient safety and quality of care"); Mulholland Presentation, *supra* note 102, at 7 (community hospitals may be victims of patient dumping and revenue loss threatens community services).

[108] G. Lynn 3/27 at 29.

incentive to over-refer patients to that facility to maximize their income.[109]

The GAO summarized these competing perspectives on SSHs:

> Advocates of these hospitals contend that the focused mission and dedicated resources of specialty hospitals both improve quality and reduce costs. Critics contend that specialty hospitals siphon off the most profitable procedures and patient cases, thus eroding the financial health of neighboring general hospitals and impairing their ability to provide emergency care and other essential community services.[110]

*Market Reaction to SSH Entry*.

According to several panelists, some general hospitals facing competition from SSHs have removed the admitting privileges of physicians involved with a specialty hospital.[111] Several panelists stated that such strategies are used to protect the viability of the general hospital and to avoid the conflict of interest that arises from a physician ownership interest in a facility to which they are referring patients.[112] These panelists do not believe that removing the hospital privileges of physician-investors harms competition, and suggest that a hospital is not required "to sacrifice the interests of [its] charitable institution in favor of the physician's self-interest."[113]

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[109] *See, e.g.*, Lesser 3/27 at 16 ("Another area of concern for speciality hospitals is the potential for supply-induced demand, or demand that's generated due to the presence of these facilities. Again, the health services research that has been done over the past decades really has shown that this issue of supply-induced demand is particularly problematic when physicians are owners and when there is excess capacity."); G. Lynn 3/27 at 30 (Specialty providers' decisions about whether and where to provide care "have an effect on the physicians personal financial interest."); Mulholland 3/27 at 60 ("Physician ownership interests influence referrals. That's almost intuitive and there have been some studies that suggest that utilization increases."); Mulholland Presentation, *supra* note 102, at 6; David Morehead, *A System in the Making* 2-3 (3/27) (slides) (physician-investors have inherent conflict of interest, including financial conflicts) [hereinafter Morehead Presentation], *at* http://www.ftc.gov/ogc /healthcarehearings/docs/morehead030326.pdf.

[110] GAO, SPECIALTY HOSPITALS, *supra* note 80, at 1.

[111] *See, e.g.*, John G. Rex-Waller, *Federal Trade Commission & U.S. Department of Justice Joint Hearing on Health Care & Competition Law and Policy* 11 (3/27), *at* http://www.ftc.gov/ogc /healthcarehearings/docs/rexwaller.pdf; Dennis I. Kelly, *Statement of Dennis I. Kelly* 17-18 (3/27) [hereinafter D. Kelly (stmt)], *at* http://www.ftc.gov /ogc/healthcarehearings/docs/030327denniskelly.pdf; Kane 4/11 at 52. This strategy is sometimes referred to as economic credentialing. D. Kelly (stmt), *supra*, at 16-17 (stating that economic credentialing is harmful to potential and existing competition from SSHs). More generally, economic credentialing has been defined as "the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges." American Medical Association (AMA) House of Delegates Resolution, H-230.975.

[112] Morehead 3/27 at 43-46.

[113] *Id*. at 47 (noting "you just can't be a partner and a competitor at the same time"); Morehead Presentation, *supra* note 109, at 4 (A "Board [is] not required to sacrifice charity's interest in favor of physician's self-interest.").

Panelists also described a number of other responses by general hospitals to the emergence of SSHs. One panelist stated that some general hospitals have established their own specialized single-specialty wing or partnered with physicians on their medical staff to open a SSH.[114] Panelists also stated that some general hospitals have reacted to the competition by removing physicians from the on-call rotation; making scheduling surgeries more difficult; limiting physician access to operating rooms; limiting physicians' "extra assignments" under which the physician can earn professional fees;[115] and using certificate of need laws to encumber specialty hospital entry.[116]

Panelists also stated that general hospitals have entered into managed care contracts with health plans that either preclude SSH entry entirely, or result in the "deselection" of physicians who invest in the SSH from the insurance companies' list of preferred providers.[117] Representatives of SSHs noted that it is difficult to compete against this behavior by providing lower prices because they cannot provide the full panoply of services a health plan requires.[118]

One panelist summarized the SSH position as follows: general hospitals have engaged in "stiff and coordinated resistence … driven not by quality, cost efficiency, or the desire to preserve the delivery of charity care to the community, but rather by the fear of having to compete, of having to look within their respective institutions to improve efficiencies and to

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[114] Lesser 3/27 at 12 (describing some hospitals as taking a "kind of preemptive strike strategy where the hospital establishes its own specialty facility in an effort to ward off the establishment of the competing facility in the market"). *See also* The Wisconsin Heart Hospital's partnership with Covenant Healthcare, *at* http://www.twhh.org.

[115] Mulholland 3/27 at 66 ("Hospitals have also determined to deny medical staff leadership position or participatory rights, for example, votes or active staff membership, to physicians with investment interests in competitors."); D. Kelly 3/27 at 76; Opelka 2/27 at 183 ("With the emergence of physician-owned specialty hospitals, some general hospitals have been denying privileges to those who participate in these ventures, particularly in geographic areas where there has been significant consolidation of hospital ownership.").

[116] Rex-Waller 3/27 at 53-54; Alexander 3/27 at 38. A new Florida law that bars licensure of any specialty hospital illustrates an example of this allegation. The law bans specialty hospitals that treat a single condition, and it eliminates its CON requirement for new adult open-heart surgery and angioplasty programs at general hospitals. The law also exempts from CON the addition of beds to existing structures, but new structures will still be required to file a CON. Fla. Bill SJ 01740 (effective July 1, 2004), *amending* FLA STAT. ch. 408.036, .0361 (2003). On Certificate of Need (CON) laws, *see infra* Chapter 8.

[117] Kane 4/11 at 52 ("[S]hortly after the heart hospital opened, we ran afoul of Blue Cross and Blue Shield in some areas, … we were what we call deselected, and we were taken off the Blue Cross and Blue Shield panels."); D. Kelly 3/27 at 75. This deselection caused some physicians to cease their involvement with the SSH, after which they were reinstated on insurance panels. Kane 4/11 at 52 ("Some of our young doctors felt like they just couldn't make it without the Blue Cross business and they went elsewhere, …. Shortly after leaving our group, … they were [on] the Blue Cross Blue Shield panels."). *But see* Mulholland 3/27 at 69-70 and Mulholland Presentation, *supra* note 102, at 17-22 (enumerating hospital actions against physicians who invest in specialty hospital, suggesting they are all "reasonable and pro-competitive responses to this type of competition").

[118] Rex-Waller 3/27 at 53.

enhance the timely delivery of patient care."[119]

*Ambulatory Surgery Centers*.
Ambulatory surgery centers (ASCs) perform surgical procedures on patients who do not require an overnight stay in the hospital. Approximately half of the ASCs are single-specialty.[120] Single-specialty ASCs generally specialize in either gastroenterology, orthopedics, or ophthalmology.[121] Most ASCs are small (two to four operating rooms). ASCs' ownership structures vary: some are completely physician owned; some are owned by joint ventures between physicians and private or publicly traded companies; some are owned by physician/hospital joint ventures; and some are owned by hospitals and hospital networks.[122] Innovations in technology have made it possible to offer a broad range of services in ASCs.[123]

ASCs require less capital than SSHs, and are generally less complex to develop because they do not require the facilities needed to offer care twenty-four hours a day, seven days a week. ASCs generally do not have emergency departments, and certificate of need regulations often are not as rigorous for ASCs, if they apply at all. ASCs were originally intended to compete with hospital inpatient units, but they now compete more against hospital outpatient surgery units.[124]

The number of ASCs has doubled in the past decade, and currently total 3,371.[125] Panelists indicated ASC development was influenced by many of the same factors spurring the growth of specialty hospitals. One panelist noted that ASCs were "a common-sense, intelligent response to a mature health care delivery system and industry gripped by inefficiencies and to health care spending being out of control."[126] Other reasons for ASC growth listed by panelists

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[119] Alexander 3/27 at 35. *See also id.* at 36 ("In an effort to forestall competition, two of the hospital systems in Columbus … recently passed resolutions to revoke existing privileges of medical staff members and to withhold new privileges solely on the basis of a physician's investment interest in NASH or any competing specialty hospital.").

[120] Beeler 3/26 at 59.

[121] Casalino et al., *supra* note 82, at 59.

[122] Beeler 3/26 at 60.

[123] Rex-Waller 3/27 at 50 (stating that the growth of ASCs "has been driven by technology, technological advances, particularly in endoscopic surgery . . . in surgical techniques, and in advanced anesthetic agents").

[124] Casalino et al., *supra* note 82, at 59 ("ASCs primarily compete now with hospital outpatient surgery departments, where most outpatient surgery is performed."). *See also* Beeler 3/26 at 63; Sacks 3/26 at 40.

[125] Casalino et al., *supra* note 82, at 59 ("In 2000, 242 new ASCs were created, and 343 were created in 2001, compared with an average of 166 annually in the preceding eight years.").

[126] Alexander 3/27 at 32.

included improved technology,[127] physician demand for efficient surgical facilities,[128] control and specialized staff, as well as "patient demand for a non-institutional, friendly, convenient setting for their surgical care, and payor demand for cost efficiencies as evidenced by the ambulatory surgery center industry."[129] One study also noted that ASCs offer patients more "convenient locations, shorter wait times, and lower coinsurance than a hospital department."[130]

Medicare reimbursement has had a profound impact on the number of ASCs and the amount of surgery performed in them.[131] Congress first approved coverage of ASCs by Medicare in 1980, as part of an effort to control health care spending by providing low-risk surgeries in a less-expensive ambulatory setting.[132] Between 1982 and 1988, Medicare paid 100 percent of the reasonable charges for approved ambulatory procedures, and waived the deductible and copayment that would apply if the procedure were provided in an inpatient setting.[133] From 1988 to 2003, the fee schedule has been based on an inflation-adjusted 1986 cost survey for ambulatory surgery. The ASC payment schedule has not been adjusted for advances in technology and productivity over the last 16 years; some procedures that were once labor-and-resource intensive are now much less costly for ASCs to perform. The MMA freezes Medicare payment rates for ASCs from 2005 through 2009 and directs the Department of Health

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[127] Technological changes include the development of flexible fiberoptic scopes used for colon cancer screening and upper GI procedures as well as advancements in microsurgery and ultrasound techniques used in cataract lens replacement. *See* MEDICARE PAYMENT ADVISORY COMM'N (MEDPAC), REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY § 2F, at 140 (2003), *at* http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf.

[128] *See, e.g.*, MEDPAC, *supra* note 127, § 2F, at 140 (noting that the specialized settings may have allowed physicians to perform procedures more efficiently than in an outpatient setting and allowed physicians to reserve surgical time).

[129] Rex-Waller 3/27 at 50. *See also* Beeler 3/26 at 62 (noting the "development of new technology and techniques for both the surgery itself and anesthesia" have allowed providers to discharge patients more quickly after surgery).

[130] MEDPAC, *supra* note 127, § 2F, at 140 (assessing coinsurance is 20 percent lower in an ASC).

[131] The anti-kickback statute, described in detail *supra* Chapter 1, has also had an effect on the rise of ASCs. The anti-kickback statute generally discourages physicians from investing in facilities to which they refer patients, but a regulatory safe harbor explicitly excludes ASCs from this prohibition. Office of the Inspector General, *Programs: Fraud and Abuse; Clarification of the Initial OIG Safe Harbor Provisions and Establishment of Additional Safe Harbor Provisions Under the Anti-Kickback Statute; Final Rule*, 64 Fed. Reg. 63,517 (Nov. 19, 1999).

[132] Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 934, 94 Stat. 2599 (1980). *See also* Shelah Leader & Marilyn Moon, *Medicare Trends in Ambulatory Surgery*, 8 HEALTH AFFAIRS 158, 158-59 (Spring 1989).

[133] Leader & Moon, *supra* note 132, at 158-59.

and Human Services to implement a new payment system by 2008.[134]

**Table 2:**
**Medicare Reimbursement Rates for Procedures Performed by Hospital Outpatient Department and ASCs**

| Description | Hospital Outpatient Rate | ASC Rate | Percent Difference |
|---|---|---|---|
| Cataract removal/lens insertion | $1,160 | $973 | -19% |
| After cataract laser surgery | 246 | 446 | 81 |
| Colonoscopy, diagnostic | 413 | 446 | 8 |
| Upper gastrointestinal endoscopy, biopsy | 387 | 446 | 15 |
| Colonoscopy with removal of lesion by snare | 413 | 446 | 8 |
| Epidural injection, lumbar or sacral | 250 | 333 | 33 |
| Colonoscopy with biopsy | 413 | 446 | 8 |
| Colonoscopy with removal of lesion by forceps | 413 | 446 | 8 |
| Upper gastrointestinal endoscopy, diagnostic | 387 | 333 | -14 |
| Cystoscopy | 329 | 333 | 1 |

Although ASCs and hospital outpatient departments perform some of the same procedures, payment varies depending on where the services are provided. Higher reimbursement for services performed in a hospital outpatient department may make sense when a patient has multiple

[134] The MMA directs the GAO to conduct a study comparing the costs of procedures in ASCs to the cost of procedures furnished in hospital outpatient departments, and make recommendations about the appropriateness of using the outpatient prospective payment system as a basis for paying ASCs. MMA § 626(d).

complicating factors making the surgery more complex. One panelist also asserted that hospitals should receive higher payments for outpatient services because they have higher overhead costs.[135] Yet, as Table 2 demonstrates, payment may be higher, lower, or the same at ASCs and hospital outpatient departments.[136] These differences create predictable incentives for providers. As former CMS administrator Tom Scully noted, when the ASC rate is high "all of a sudden you start seeing ASCs pop up all over the place to do colonoscopies or to do outpatient surgery …. If the hospitals get paid a little more, they're going to have more outpatient centers."[137]

Many of the concerns expressed by panelists about SSHs were also expressed about ASCs. Panelists asserted that ASCs are eroding the outpatient market share of hospitals that hospitals depend upon, that ASCs do not care for Medicaid beneficiaries, they "skim and cherry-pick on the front end regarding [] the finances of the patient," and that ASCs only enter areas where business is profitable.[138] One ASC representative suggested that reimbursement should be modified based on the acuity of the patient, but denied that ASCs refuse to care for Medicaid patients.[139]

*Market Reaction to ASC Entry*.
Panelists indicated that many of the actions taken to curb entry of specialty hospitals are also being employed against ASCs. One panelist suggested that entry and competition for ASCs have been made difficult by hospitals engaging in legislative efforts to encumber ASCs with unnecessary regulation and mandatory services.[140] Another panelist described how some hospitals have negotiated discounted prices for inpatient services in exchange for exclusive contracts for outpatient surgery.[141] One panelist noted that some general hospitals have revoked privileges of physician-investors in ASCs, and used state certificate of need (CON) laws to inhibit ASC entry.[142]

*Competitive Evaluation of Entry*. In
general, the Agencies favor the elimination of anticompetitive barriers to entry, on the grounds that robustly competitive markets in which entry and exit is determined by market forces

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[135] Andrew 3/26 at 118.

[136] MEDPAC 2003, *supra* note 127, § 2F, at 143, Table 2F-3.

[137] Scully 2/26 at 46.

[138] Andrew 3/26 at 12; Sacks 3/26 at 41 ("It is the profitable business, and that continues to be picked away by this type of competition.").

[139] Beeler 3/26 at 116-117; Andrew 3/26 at 14-15.

[140] Rex-Waller 3/27 at 53.

[141] Beeler 3/26 at 63-64.

[142] *Id*. at 64.

maximizes consumer welfare. Entry by SSHs and ASCs has had a number of beneficial consequences for consumers who receive care from these providers. It cannot be overlooked, however, that Medicare's administered pricing system has substantially driven the emergence of SSHs and ASCs.

Generally speaking, antitrust law does not limit individual hospitals from unilaterally responding to competition either by terminating physician admitting privileges or by approaching state governments in connection with CON proceedings.[143] If there is specific evidence of anticompetitive conduct by individual hospitals or of hospitals colluding together against efforts to open a SSH or ASC, then the Agencies will aggressively pursue those activities.

## IX. THE IMPACT OF GOVERNMENT PURCHASING

CMS has tremendous bargaining power in the market for medical services, and providers are extremely responsive to the signals sent by CMS.[144] Prior to the adoption of the IPPS, average hospital length-of-stay had been stable for 7 years. Once IPPS went into effect, length of stay began an immediate decline, the number of inpatient cataract surgeries dropped precipitously (from 630,000 to 211,000 in one year), and the number of hospital outpatient cataract surgeries immediately increased by 128 percent.[145] Similarly, the adoption of prospective payment for home health care had an immediate impact on the number of beneficiaries that received services and the average number of visits.[146]

Medicare's administered pricing system can also (albeit generally inadvertently) make some services extraordinarily lucrative, and others unprofitable. The result of the pricing distortions is that some services are more or less available than they would be based on the demand for the services – which in turn triggers adaptive responses by providers.[147] One panelist

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[143] Of course, under some circumstances, a unilateral response can still constitute a violation of Section 2 of the Sherman Act, and there are sham and misrepresentation exceptions to the *Noerr-Pennington* doctrine. *See infra* Chapter 8.

[144] *See, e.g.*, Hammer 2/27 at 51-52 (noting that Medicare should "be aware of its conduct that is both market-shaping and market-facilitating. When Medicare chooses to reimburse a new technology, it creates a new market."). It should be noted, however, that CMS would have even more power if it were permitted to engage in selective contracting.

[145] *See* Pope, *supra* note 18; *See also* AMERICAN HOSPITAL ASS'N, *supra* note 12, at 2 tbl.1; Leader & Moon, *supra* note 132, at 159.

[146] CMS, *supra* note 4, § 3(D), at 9 (Persons Served and Average Number of Visits by Home Health Agencies).

[147] *See, e.g.*, Hammer 2/27 at 52 (noting that when CMS "has a misalignment of the regulatory pricing system, . . . it creates competition gaming the regulatory system); Scully 2/26 at 28, 46 ("So, when the government, either Federal or State, is fixing prices, the rest of the market's flexibility to respond to that is kind of muted . . . I

noted these difficulties are compounded by the fact that the balance of the population relies for its health care services on an infrastructure built in response to the excesses and inadequacies of Medicare's administered pricing system.[148]

Consider cardiac care. Commentators and panelists suggested that CMS never made a deliberate decision to provide for greater profits for such services relative to the amounts paid for other inpatient services but the IPPS does so.[149] General hospitals use these profits to subsidize the provision of less profitable (or unprofitable) services, but the pricing distortion creates a direct economic incentive for SSHs to enter the market. In response, general hospitals complain to legislators and try to find ways to limit the expansion of competition. Absent the distortions created by the excess profits for cardiac services in Medicare's administered pricing system, the incentive for SSH entry would be less.

These difficulties are magnified when the government is the sole or primary purchaser of a good or service. Paying too much wastes resources, while paying too little reduces both output and capacity, lowers the quality of the services that are provided, and diminishes the incentives for innovation.[150] Some commentators have suggested that these adverse consequences have materialized in the market for vaccines.[151]

Although CMS can set prices, there are limitations to CMS's ability to create incentives that encourage price and non-price competition among providers. CMS does not have the freedom to respond as a private purchaser would to changes in the marketplace. For example, CMS has only limited authority to contract selectively with providers or to use competitive

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can tell you when I drive around the country and see where ASCs are popping up, I can tell who we're overpaying.").

[148] Sage 5/29 at 148 ("Public purchasing distorts prices, overbuilds capacity, and skews the development and dissemination of technology.").

[149] *See, e.g.*, Ginsburg 2/26 at 65 ("Medicare sets the DRG rates, … but their productivity gains are much faster in cardiovascular services so that, in a sense, the rates become obsolete fairly quickly ….''); KELLY DEVERS ET AL., SPECIALTY HOSPITALS: FOCUSED FACTORIES OR CREAM SKIMMERS? (Ctr. for Studying Health Sys. Change, Issue Brief No. 62, 2003), *available at* http://www.hschange.com/CONTENT/552/ (reporting statements of hospital executives that certain surgical procedures (*e.g.*, cardiovascular and orthopedic) are among the most profitable surgeries, and that it is unlikely that payors intended to create these distortions in payment rates).

[150] Pauly 2/26 at 93-94 (noting that "[i]f the regulated price is too high, you'll get excessive socially inefficient quality. If the regulated price is too low, you'll get socially deficient quality . . . .").

[151] BOARD ON GLOBAL HEALTH & INSTITUTE OF MEDICINE, MICROBIAL THREATS TO HEALTH: EMERGENCE, DETECTION, AND RESPONSE 187 (2003) ("[O]nly four leading companies worldwide have been responsible for developing new vaccines during the past two decades. It was not mergers and acquisitions that concentrated responsibility for vaccine innovation … rather, the economic forces that drove firms out of the industry were the rising costs of innovation, production … and the shrinking margins allowed by monopsony.").

bidding to meet its needs.[152] With limited exceptions, CMS cannot force providers to compete for CMS's business or encourage suppliers to reduce their costs and enhance their quality by rewarding them with substantially increased volume or substantially higher payments if they do.[153]

Even straightforward purchasing initiatives, such as competitive bidding for durable medical equipment (DME), have generated considerable resistance. A pilot project resulted in Medicare savings between 17 and 22 percent with no significant adverse effects on beneficiaries.[154] Opponents of competitive bidding have argued, however, that the bidding process increased bureaucracy, decreased consumer choice, threatened the existence of small manufacturers, and lowered quality.[155] At least one industry representative has called for the repeal of the provisions mandating competitive bidding.[156]

As Chapter 1 reflects, with limited exceptions, CMS's payment systems do not reward higher quality care, or punish lower quality care. Indeed, as the Medicare Payment Advisory Commission (MedPAC) noted, the Medicare payment system is "largely neutral or negative towards quality. All providers meeting basic requirements are paid the same regardless of the quality of service provided. At times providers are paid even more when quality is worse, such as when the complications occur as the result of error."[157] Former CMS administrator Scully was more pointed: Medicare pays every hospital in a region "the exact same amount for hip replacement and the same amount for a heart bypass, if you're the best hospital or the worst hospital."[158]

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[152] 42 U.S.C. §§ 1395, 1395a, 1395b. *See also supra* Chapter 1.

[153] *See* Pauly 5/28 at 48 ("Administered price can cause competition to be a function of quality."); David A. Hyman, *Does Quality of Care Matter to Medicare?* 46 PERSP. BIO. & MED. 55-68 (2003).

[154] Centers for Medicare & Medicaid Services, *Evaluation of the Durable Medical Equipment Competitive Bidding Demonstration*, *at* http://www.cms.hhs.gov/researchers/demos/DMECB.asp (last modified Feb. 18, 2004). Centers for Medicare & Medicaid Services, *Medicare Pilot Project For Durable Medical Equipment in Polk County, Fla*. (May 29, 1998), *at* http://www.cms.hhs .gov/healthplans/research/dmeshrt.asp.

[155] American Ass'n for Homecare, *Myths and Facts About Medicare Competitive Bidding for Durable Medical Equipment* (Sept. 5, 2002), *at* http://www.aahomecare.org/govrelations/myths-cb.pdf. *See also* Nat'l Ass'n for Homecare & Hospice website, *at* http://www.nahc.org/NAHC/LegReg /0304Landrieu_HME_signon.html.

[156] Cara C. Bachenheimer, *Prescription for Change*, HOMECARE, Jan. 1, 2004, *at* http://www. homecaremag.com/ar/medical_prescription_change/.

[157] MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: VARIATION AND INNOVATION IN MEDICARE 108 (2003), *at* http://www.medpac.gov/publications /congressional_reports/June03_Entire_Report.pdf.

[158] Scully 2/26 at 34; Antos 9/30 at 123 ("We now have major financial rewards for the system to not work right."). *See also* Kahn 2/27 at 73 (noting that "at the end of the day, you have prices that are arbitrarily set that really don't relate very closely to any kind of market scheme that we could define").

To be sure, these problems are not unique to Medicare. The Institute of Medicine noted that "current [compensation] methods provide little financial reward for improvements in the quality of health care delivery, and may even inadvertently pose barriers to innovation."[159] The Agencies encourage the use of payment strategies that create an incentive for providers to deliver higher quality care to consumers.

Medicare also includes a managed care option, the Medicare Advantage (MA) program.[160] MA programs provide Medicare beneficiaries with a range of managed care options, including HMOs and preferred provider organizations. MA allows Medicare beneficiaries to join privately operated managed care plans.[161] The plans are paid an administratively determined rate by Medicare and plans also may charge an additional premium and offer additional benefits.[162] Medicare beneficiaries who joined MA plans often received greater benefits (*e.g.*, prescription drug coverage) in exchange for accepting limits on their choice of providers.[163] In 2002, MA plans (then the Medicare+Choice (M+C) plan) provided health care to 5 million Medicare beneficiaries, down from 6.35 million enrollees in December 1999.[164] One panelist testified that although the Medicare program has attempted to introduce competitive pricing as a way to set payment rates to M+C plans, to date none of those plans have been successful.[165] As a result, Medicare continues to establish the payment rates administratively.[166] According to this

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[159] INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 193 (2001). *See* Carolyn Clancy, *AHRQ and HHS Efforts to Improve Quality* 28 (5/27) (slides) (showing that only 10 percent of the population receive excellent quality health care), *at* http://www.ftc.gov/ogc/healthcarehearings/docs/030527clancy.pdf.

[160] As part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the Medicare+Choice program (M+C) was renamed to Medicare Advantage (MA).

[161] *See* U.S. DEP'T OF HEALTH & HUMAN SERVICES (HHS), MEDICARE & YOU: 2004, § 6, at 44-52, *available at* http://www.medicare.gov /publications/pubs/pdf/10050.pdf.

[162] Pizer 4/23 at 146-47; Steven Pizer, *Competition in the Medicare+Choice Program* 5 (4/23) (slides) [hereinafter Pizer Presentation], *at* http://www.ftc.gov/ogc/healthcarehearings/docs/pizer.pdf; Steven Pizer & Austin Frakt, *Payment Policy and Competition in the Medicare+Choice Program*, 24 HEALTH CARE FIN. REV. 83 (2002).

[163] *See* HHS, *supra* note 161, § 6, at 44-52; Pizer Presentation, *supra* note 162, at 5; Pizer & Frakt, *supra* note 162.

[164] Pizer & Frakt, *supra* note 162, at 83 & n.1.

[165] Pizer 4/23 at 147.

[166] Beginning in 2006, however, MA plans will be paid under a new competitive method. Plan bids will be compared to benchmarks calculated for each area based on the costs of fee-for-service Medicare. If a plan bid is higher than the benchmark, the enrollee will pay the difference. If it is lower, 75 percent of the difference will go to the enrollee as extra benefits or as a rebate; the remaining 25 percent will be retained by the government. *See* Health Policy Alternatives, *Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Executive Summary* 2 (Nov. 30, 2003), *at* http://www.achp.org/media/hpaexecutive.pdf.

speaker, to the extent plans compete, it typically has been on the benefits they provide.[167]

## X. HOSPITAL/PAYOR CONTRACTING IN THE PRIVATE MARKET

Contracting between hospitals and private payors has been controversial and contentious. Several panelists asserted that hospital systems routinely "terminate then negotiate" for large increases in reimbursement, and use the media to scare the public.[168] Panelists also stated that hospital systems insist that all hospitals in the system be included in a payor network ("all or nothing contracts"), irrespective of whether the payor actually wants to include the entirety of the hospital system.[169] Panelists representing hospitals responded that they are protecting their institutions' interests and that their services had been artificially and unsustainably underpriced in the past.[170] These dynamics have played out in several markets in the past few years.[171] Although commentators have noted that particular hospitals and systems seem to have the upper hand in some markets, whether hospitals or health plans have bargaining advantages varies substantially within and among different markets.[172]

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[167] Pizer 4/23 at 147.

[168] *See, e.g.*, Berman 2/28 at 80-82 (describing contract negotiations between Partners HealthCare and Tufts Health Plan); Spetz et al., *supra* note 50, at 226-27 (describing how, in Sacramento, Sutter Health threatened to cancel contracts with Blue Cross and other insurance plans if reimbursement was not increased; other hospital systems followed Sutter Health's lead in Sacramento and in other regions in California); Strunk 3/27 at 161; Iselin 3/27 at 180 ("We've seen quite a bit of brinkmanship, . . . including . . . termination as a prelude to negotiation."); Lesser 9/9/02 at 87; Kanwit 9/9/02 at 175.

If the contract between a hospital and payor includes an "evergreen" clause, the contract renews automatically unless one party serves the other party with a notice of termination. Thus, the termination notice may simply reflect the desire of one party to renegotiate the terms of the contract. *See* Fine 9/9/02 at 222-23 (noting that "hospital contracts all contain within them evergreen provisions, automatic renewal provisions, that if cancellation or termination is not effected within 60 or 90 days prior to the expiration date, that contract automatically rolls over for another three to five year term").

[169] Kanwit 2/27 at 98-99 (describing a practice called "all or nothing" "where the hospital systems [] requir[e] health plans to contract with freestanding facilities, radiology facilities, [and] ambulatory surgery facilities"); Strunk 3/27 at 161 ("[W]e've observed systems that contain a highly reputable and desirable flagship hospital, threatening to cut ties with the plan, unless the plan is willing to contract with and provide favorable rates to the other hospitals in the system, even if the other hospitals are less desirable to the plan."). Stephanie Kanwit, *Perspectives on Competition Policy and the Health Care Marketplace* 4-5 (2/27), *at* http://www.ftc.gov /ogc/healthcarehearings/docs/kanwitstephanie.pdf.

[170] *See, e.g.*, F. Miller 2/28 at 92; Mongan 2/28 at 110.

[171] JUSTIN WHITE ET AL., GETTING ALONG OR GOING ALONG? HEALTH PLAN-PROVIDER CONTRACT SHOWDOWNS SUBSIDE 2 (Ctr. for Studying Health Sys. Change, Issue Brief No. 74, 2004), *available at* http://www.hschange.org /CONTENT/641/.

[172] *See, e.g.*, Scully 2/26 at 52 (describing the Alabama market and stating "there is one insurance in Alabama"); D. Hall 4/25 at 74-75 (stating that Blue Cross/Blue Shield "insure[s] and control[s] about 80 percent of all the non-governmental work in the State of Alabama"); Mansfield 4/25 at 86-88 (describing the Little Rock market as sharing one dominant hospital system and one dominant insurance provider which have entered a

Generally speaking, payors seek to contract with hospitals that contribute to the marketability of their insurance products.[173] Factors that affect marketability include the price of coverage, the number of hospitals at which care can be provided, the perceived quality, desirability, and accessibility of those institutions, and the alternative insurance products that are available in the market. Payors seek to balance the price of the hospital services they must purchase to offer insurance coverage against the desirability of the resulting network to the purchasers of their insurance products. If patients view several hospitals as adequate substitutes for one another, it will be easier for the payor to threaten credibly to exclude one or more of these hospitals. Conversely, if enrollees will drop an insurance plan if their preferred hospital is no longer in the network, the hospital will find it easier to insist on higher reimbursement.

Multi-hospital systems frequently seek to ensure that all system hospitals are included in a payor network. Consumer pressure for open networks has made it more difficult for payors to exclude an entire hospital system outright, which affects the bargaining dynamics. In a few markets, payors have sought to "tier" hospitals.[174] Tiering results in different consumer copayments (*i.e.*, high or low cost sharing) depending on the hospital at which care is provided.[175] Hospital tiers may be established using a wide variety of criteria. Tiering generally does not apply to emergency admissions, and may depend upon where routine and specialty services are offered.[176]

For payors, tiering offers a potential response to multi-hospital system pressure for inclusion of all system hospitals within a payor network. Tiering allows the payor to maintain a broad network, and include a "must-have" hospital, but simultaneously creates an incentive for

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"partnership"); F. Miller 2/28 at 95-97 (describing the Boston market and her belief that one hospital system has negotiating power over insurers); Prairie Health Purchasing Alliance, *Comments Regarding Competition Law and Policy & Health Care (Sept. 27, 2002)* (Public Comment).

[173] *See generally* Gregory Vistnes, *Hospitals, Mergers and Two Stage Competition*, 67 ANTITRUST L. J. 671, 674 (2000). A marketable network is one that is not too expensive and includes hospitals that enrollees and plan physicians want. Complex rules can make a plan less marketable.

[174] Monk 4/23 at 44; Arthur Lerner, *Statement of Arthur Lerner* 2-3 (3/27) [hereinafter Lerner (stmt)], *at* http://www.ftc.gov/ogc /healthcarehearings/docs/030327arthurlerner.pdf; Jill M. Yegian, *Tiered Hospital Networks*, 2003 HEALTH AFFAIRS (Web Exclusive) W3-147, 148, *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.147v1.pdf; *see* GLEN P. MAYS ET AL., TIERED-PROVIDER NETWORKS: PATIENTS FACE COST-CHOICE TRADE-OFFS 2 (Ctr. for Studying Health Sys. Change, Issue Brief No. 71, 2003) (describing plans testing tiered networks in Seattle, Washington, Miami, Florida, Syracuse and northern New Jersey), *available at* http://www.hschange.org/CONTENT /627.

[175] O'Kane 5/30 at 71 (tiering seen as a way to reward quality); Robert Steinbrook, *The Costs of Admission: Tiered Copayments for Hospital Use,* 350 NEW ENGL. J. MED. 2539 (2004).

[176] James C. Robinson, *Hospital Tiers in Health Insurance: Balancing Consumer Choice with Financial Incentives*, 2003 HEALTH AFFAIRS (Web Exclusive) W3-135, 137, *at* http://content .healthaffairs.org/cgi/reprint/hlthaff.w3.135v1.pdf.

consumers to use lower-cost providers.[177] Panelists offered a range of views on the prospects of tiering.[178]

Blue Shield of California provides one example of tiered hospital benefits. Blue Shield tiers within geographic areas and seeks to promote choice among community hospitals and teaching hospitals.[179] Hospitals are sorted by region and teaching status and coverage benefits are designed to operate within these groupings. Blue Shield also uses some quality performance measures in its tiering criteria.[180] Hospitals are assigned to a "choice" tier unless their prices exceed the average for their region and teaching status, in which case they are assigned to an "affiliate" tier.[181] Blue Shield introduced this product in April 2002. Approximately, one million of its 2.3 million members have a tiered network benefit package. Blue Shield tiers inpatient and outpatient services, ambulatory surgery centers, and radiation and chemotherapy services.[182]

Similarly, Tufts Health Plan also attempted to use tiering in Boston, Massachusetts.[183] Teaching hospitals provide the majority of hospital services within Boston and are typically more expensive than community hospitals.[184] Tufts tried to use tiering to steer its members to

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[177] Lerner (stmt), *supra* note 174, at 12.

[178] *See* Strunk 3/27 at 206 ("We haven't seen huge savings from them yet, but it is, you know, too early to tell. They had two tiers, a preferred and I guess a non-preferred, . . . but it ended up that [] a huge percentage of the hospitals ended up being in the preferred tier anyway. So, in the end, there wasn't all that much steerage to do in the first place . . . ."); Iselin 3/27 at 180 ("[W]here people have tried tiering or floated it, it's common that it is outright refused."). Other panelists suggested that tiering may be an easy tool for payors. *See* Guerin-Calvert 3/27 at 147 ("I would agree completely that tiering of networks has proven to be the second easiest and most likely tool that payors are turning to . . . ."); Argue 3/28 at 50 ("[T]here are a number of new mechanisms that are showing up in the literature," including tiering and "variable premiums.").

[179] Robinson, *supra* note 176, at 139.

[180] *Id*. at 140 (the measures are whether a hospital participates in the Leapfrog program and a facility's scores on patient satisfaction surveys). Also in California, PacifiCare has instituted a narrow, two-tiered network and projects 6 to 16 percent premium savings for its beneficiaries. *Id*.

[181] Robinson, *supra* note 176, at 139-40 (the tiering payment schedule divides the hospitals within the individual market into the following categories: choice hospitals – HMO members have no admission copayment and PPO members have a 30 percent coinsurance; affiliate hospitals – HMO members have a $150 admission copayment and PPO members have 40 percent coinsurance).

[182] Robinson, *supra* note 176, at 140.

[183] Berman 2/28 at 123.

[184] Massachusetts Council of Community Hospitals (MCCH), *Cape Ann Economics Report for MCCH (June 2001*) (Public Comment) ("Massachusetts residents now utilize a teaching hospital setting for inpatient care 2.5 times the national average"); Altman 2/28 at 17 ("We are in love with our teaching hospitals . . . . And this is – it's just the nature of Massachusetts health care, and if you are looking at teaching hospitals' spending per capita in

community hospitals.[185] After a very public battle, Tufts backed away from its plans and made tiering voluntary for its members.

Some hospitals resist tiering, and if they have sufficient bargaining power, they can credibly threaten to withdraw from a payor network if they are placed in an unfavorable tier.[186] Hospital systems can similarly threaten to pull all of their hospitals from a network if any system hospital is placed in an unfavorable tier. In some markets, hospital systems have taken preemptive steps to negotiate contract language with plans that prohibit tiering.[187] Panelists and analysts noted a number of reasons (beyond straight financial issues) why hospitals may resist tiering. Low-cost facilities fear being labeled as low quality and high-cost facilities fear being deemed inefficient.[188] If tiering is price-driven, it may be difficult for facilities to maintain expensive areas of care like burn units, trauma services, and emergency "standby" capabilities.[189] Hospital representatives also expressed concern that individual hospitals are not fungible substitutes, and tiering might result in bad consumer choices.[190] Hospital representatives have also expressed concern that tiering might force poor consumers to patronize only low-quality, low-cost hospitals.[191] One critic of hospital tiering believes that tiering will put indigent care, teaching facilities, and innovative research at risk, and believes "there is no justification for putting patients in the middle of … health care financing" – particularly when the available

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1998, which our task force looked at, we spent $168 per capita, where the rest of the country spent $42 per capita.").

[185] Robinson, *supra* note 176, at 140 (copayment for community hospital inpatient and outpatient services are $350; copayment for tertiary centers is $600).

[186] Ginsburg 2/26 at 72 ("[W]e have seen instances in our sites where hospitals have resisted tiered networks, such as in California, basically by threatening not to contract with the plan if they're placed in the lower, less attractive tier."); Lerner (stmt), *supra* note 174, at 3 ("[S]ome hospital systems are demanding that … [the system's] services, be included in the richest benefit tier of every product the plan sells."); Lesser 9/9/02 at 96-97. *See also* Milstein 2/27 at 103-04 (suggesting the Agencies "assure performance-based tiering of providers" and not allow "[a]ggregated provider organizations to restrain insurers from classifying individual providers into performance tiers").

[187] MAYS ET AL., *supra* note 174 (describing plan attempts to develop tiering thwarted by large hospital systems that refused to participate and threatened to drop out of the network).

[188] Robinson, *supra* note 176, at 143.

[189] Yegian, *supra* note 174, at 150.

[190] Panelists compared hospital tiering to pharmaceutical tiering, where there was greater agreement that tiering could beneficially encourage consumers to use generic drugs instead of branded pharmaceutical equivalents. *See, e.g.*, Altman 2/28 at 124-25.

[191] MAYS ET AL., *supra* note 174 (noting some fear that "designs based primarily on cost will result in the most desirable providers – which could be more costly – being placed in nonpreferred tiers, making them accessible only to those who can pay extra"). *But see* Robinson, *supra* note 176, at 145 ("[N]ontiered hospital networks do not subsidize the poor at the expense of the rich. Low-quality hospitals are not typically to be found in high-income neighborhoods, and well-heeled consumers do not drive across town to seek them.").

information about quality is less than perfect.[192]

Because tiering is a relatively new development, there are no systematic studies available on the prevalence or consequences of this strategy. Additional research would be useful in determining whether consumers in tiered plans actually use lower priced hospitals, and whether they would have used those hospitals without the tiering.

## XI. CONSUMER PRICE SENSITIVITY AND INFORMATION

Tiering represents an attempt to force consumers to bear some of the increased price associated with receiving care at a more expensive hospital.[193] Medical savings accounts are intended to accomplish the same goal.[194] That is, both strategies attempt to raise consumer sensitivity to the costs associated with the health care decisions. For these strategies to work effectively, however, consumers will need access to good information about the price and quality of the services they must choose between.[195] A consumer facing a 25 percent co-payment at one hospital and a 15 percent co-payment at another can not accurately assess the financial consequences of choosing one hospital over the other absent good information about the price of the services that will be rendered at both hospitals.[196]

Most insured consumers are "rationally ignorant" of the price of the medical services

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[192] Thomas M. Priselac, *The Erosion of Health Insurance: The Unintended Consequences of Tiered Products by Health Plans*, 2003 HEALTH AFFAIRS (Web Exclusive) W158, 160, *at* http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.158v1.pdf.

[193] Robinson, *supra* note 176, at 137 ("The tiered designs are not conceptualized as a means to insulate the health plans from hospital cost variation but, rather, as a means to inform and sensitize the patient, who previously was insulated from and indifferent to the cost implications of hospital choice."); Yegian, *supra* note 174, at 147 (tiers make "cost differences among hospitals more transparent to consumers and allow consumers to decide whether a high-cost facility merits additional out-of-pocket spending").

[194] Medical Savings Accounts (MSA) and Health Savings Accounts (HSA) are tax-exempt accounts that allow consumers to accumulate savings to pay for medical expenses. They have different contribution levels, deductible ranges, and maximum levels for out-of-pocket expenses. Both MSAs and HSAs are part of the movement to consumer-driven health care and put greater responsibility for health expenses on the consumer. *See* Press Release, U.S. Dep't of Treasury, 21st Century Medicare: More Choices – Better Benefits: Health Savings Account (HSAs) (Dec. 22, 2003), *at* http://www.ustreas.gov /offices/public-affairs/hsa/press/ (accessible through "Fact Sheet on Health Savings Account"); *infra* Chapter 5.

[195] *See, e.g.*, Commissioner Thomas B. Leary, *Special Challenges for Antitrust in Health Care*, ANTITRUST MAG. 25, Spring 2004 ("It is therefore worthwhile to consider the implications of a system that would provide more information on objective measures of the quality of medical care. If this were possible, it would facilitate cost-benefit tradeoffs by payors and ultimate consumers of medical products and services. It could also encourage compensation based more overtly on outcomes rather than on inputs, and perhaps lead to a more rational allocation of resources.").

[196] Of course, consumers will also want information about the quality of the services they will receive at both hospitals. The availability of such information is addressed in *supra* Chapter 1.

they receive, because insurance largely insulates them from the financial implications of their medical treatment.[197] Consumers who pay the same co-payment regardless of the price of the treatment they receive have no reason to inquire into the price of the treatment, or to factor that price into their decision. Consumers who have co-payments that vary depending on where they receive care will still focus on the amount of the co-payment, and not on the total price of the services they receive. Even if consumers are interested in knowing the total price of the care they receive, they would find it extremely difficult to obtain that information, and are likely to find it to be complicated and obscure.[198] Proposals to increase consumer price sensitivity must confront this reality, and develop strategies to increase the transparency of hospital pricing. To be sure, these difficulties do not apply to payors, who deal with multiple providers in multiple geographic and product markets, and use pricing information to make contracting decisions.

## XII. HOSPITAL PRICING: DISTINGUISHING AMONG BULK PURCHASING, PRICE DISCRIMINATION, COST SHIFTING, AND CROSS SUBSIDIES

Understanding hospital pricing requires an understanding of four terms: bulk purchasing, price discrimination, cost shifting, and cross subsidies. The terms have distinct meanings, although there is some overlap between cost shifting and cross subsidies.

Bulk purchasing usually occurs when large organizations (*e.g.*, insurance companies) receive purchasing discounts because of the volume of their purchases. This type of purchasing can help reduce the cost of health care because the bulk purchasing capability can be used to obtain a large discount. For example, insurance companies often secure better hospital care rates for their beneficiaries than uninsured individual may obtain.[199] There is nothing unusual about

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[197] Herbert Simon, *A Behavioral Model of Rational Choice*, *in* MODELS OF MAN (1957).

[198] *See* Frech 3/26 at 198 ("[A] typical hospital will have at least tens, and maybe hundreds of payors with different prices. Not only that, the prices – they're not only different, the very bases of the price, what gets priced, is different. You'll have charges, fee for service, you'll get discounts off of charges . . . ."); Herzlinger 5/27 at 89-90 (observing "there is virtually no price quality information. You ever try to find out what the price is for a certain procedure? I mean you'd think [its] probably easier to get some information out of the FBI."); Busey 9/24 at 117-18 ("I think it's fairly well known that there is a lack of information or an uneven amount of information among players in the health care industry, and I can illustrate that by asking any of you, do you know how much your doctor charges for an office visit, and do you know how much you pay, and does it vary from the time of the year . . . . Again, that information is not as readily available in this market as it might be in other markets."). *See also* Uwe E. Reinhardt, *Can Efficiency in Health Care Be Left to the Market?*, 26 J. HEALTH POL., POL'Y & L. 967, 986 (2001) ("[O]ne need only imagine a patient beset by chest or stomach pain in Anytown, USA, as he or she attempt to 'shop around' for a cost-effective resolution to those problems. Only rarely, in a few locations, do American patients have access to even a rudimentary version of the information infrastructure on which the theory of competitive market and the theory of managed care rest. The price of health services are jealously guarded proprietary information.").

[199] Fraser 5/29 at 273 (noting the "huge gap between the retail price and the negotiated price, the only people who pay retail are the uninsured"); Milstein 5/29 at 272 ("[R]ight now we have a circumstance in many markets in this country in which the difference between the negotiated price and the rack rate, the retail rate, is breathtaking and bears no resemblance to anything that would happen in virtually any other industry."); Roy Meidinger, *Health Industry: Great Intentions Gone Bad* (Public Comment).

this behavior and it has a long history in commercial practice, in the courts, and in economic analysis.

The conventional definition of price discrimination is different ratios of price (P) to marginal cost (MC) for the same service across different buyers. That is P/MC for consumer "j" is not equal to P/MC for consumer "k".[200] For example, senior citizens may pay less to watch the same movie at the same time as other adults. Like bulk purchasing, price discrimination has a long history in commercial practice, in the courts, and in economic analysis.[201]

Cost shifting refers to raising the price charged to one group of consumers as a result of lowering the price to other consumers. An example would be a hospital raising the price to privately insured patients because the government lowered the price it paid for Medicare patients.[202] The hospital raises the privately insured prices closer to the profit maximizing level. There are three essential elements to cost shifting:[203] (1) the company or hospital must have market power that it has not exploited; (2) in response to a payor lowering its price, the company raises its prices to other payers; and (3) the ability to cost-shift is limited by the profit maximizing price. Some economists will concede that cost-shifting may exist as a matter of theory for non-profit maximizing firms, but question whether it actually occurs.[204]

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[200] *See* GEORGE J. STIGLER, THE THEORY OF PRICE 210 (4th ed. 1987).

[201] Certain types of price discrimination are, however, prohibited by Section 2 of the Clayton Act as amended in 1936.

[202] *See, e.g.*, Paul B. Ginsburg, *Can Hospitals and Physicians Shift the Effects of Cuts in Medicare Reimbursement to Private Payors?*, 2003 HEALTH AFFAIRS (Web Exclusive) W3-472, 473 ("An example would be if hospitals raised prices to private payers in response to Medicare payment rate reductions."), *at* http://content.healthaffairs.org /cgi/reprint/hlthaff.w3.472v1.pdf. One analyst believes that state legislators account for cost shifting when setting Medicaid rates, and are more willing to underpay hospitals than nursing homes because they know Medicaid "is only 10 percent of hospitals' revenues on the patient side, but it's 60, 70, 80 percent of nursing homes' revenue." Jason S. Lee et al., *Medicare Payment Policy: Does Cost Shifting Matter?*, 2003 HEALTH AFFAIRS (Web Exclusive) W3-480, 485 (referring to comments made by Stuart Altman), *at* http://content.healthaffairs.org/cgi /reprint/hlthaff.w3.480v1.pdf.

[203] MICHAEL A. MORRISEY, COST SHIFTING IN HEALTH CARE: SEPARATING EVIDENCE FROM RHETORIC, at Ch. 2 (AEI Press, 1994).

[204] Economists have been skeptical about the existence of cost-shifting. *See* David Dranove & William D. White, *Medicaid-Dependent Hospitals and Their Patients: How Have They Fared?*, 33 HEALTH SERVICES RES. 163, 165 (1998) (finding that "although California hospitals dependent on Medicaid were hit hard by Medicaid cutbacks in the period 1983-1992, they did not raise prices to privately insured patients …. This suggests either (a) that they were unable to cost-shift, and/or (b) that they were not desirable to managed care payers."); MICHAEL A. MORRISEY, HOSPITAL COST SHIFTING, A CONTINUING DEBATE (Employee Benefit Research Inst., Issue Brief No. 180, 1996) (examining the evidence on hospital cost shifting and suggesting cost shifting, to the extent it may have once existed, no longer exists because of competition in hospital markets). *See also* Jack Zwanziger et al., *Can Cost Shifting Continue in a Price Competitive Environment?*, 9 HEALTH ECON. 211 (2000) (providing evidence of the empirical importance of cost-shifting). *But see* Desmarais 2/27 at 212-13 (stating that "our member [insurance] companies are concerned about cost shifting, in that the public payers are not paying the cost of the care for their recipients and

Cross subsidizing is the practice of charging supracompetitive prices to some payors or for some services and using the surpluses to subsidize other payors or other clinical services. Cross subsidization is similar to cost shifting in that it can occur if a non-profit-maximizing firm has market power. Cross-subsidies can occur if there are barriers to entry in a market and a non-profit-maximizing firm receives greater profits on some services (*e.g.*, from Medicare for cardiac services) that it uses to underwrite the provision of other services.[205] In a competitive market, such cross-subsidies are competed away.[206] Hospital panelists see cross subsidies not as a theory, but as a fact of life:

> [If we] take away those profitable services and leave the hospital, the community hospital, with just the unprofitable services, one of two things is going to happen. Either services will be diminished to the community in a way that is not transparent, in a way that they cannot see that happening, or costs will be shifted back to other payors, and business and labor and consumers end up absorbing them, once again, not in a transparent way where they can see what's happening.[207]

As noted previously, Congress has created direct subsidies for certain hospitals. CMS pays more (approximately $5.9 billion extra in 1999) to teaching hospitals and it pays more (approximately $5 billion per year) to safety net hospitals that provide a disproportionate share

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beneficiaries, and as a result it just tends to add more pressure on the remainder of the marketplace to try to 'make up the difference ….'").

[205] Commentators state that for-profit hospitals are less likely to offer non-remunerative services. *See* Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-for-Profit Hospitals*, 50 UCLA L. REV. 1345, 1367-76 (2003) (finding increased probability of non-remunerative services offered by nonprofit hospitals); Linda B. Miller, *The Conversion Game: High Stakes, Few Rules*, 16 HEALTH AFFAIRS 112, 116 (Mar./Apr. 1997) ("These services – such as burn units, perinatal intensive care units, transplantations, and other sophisticated medical interventions – exist overwhelmingly in the nonprofit sector and represent an investment in a social good, not potential financial returns.").

[206] *See, e.g.*, Blumstein 2/27 at 30 ("[A]ntitrust evaluates conduct on grounds of competition and efficiency. It encourages competing away excess profits and cross-subsidization. This is something that the health system has lived on for many years, but it is hard to do when super-competitive profits are being competed away and that many monopolies are being targeted."); Brewbaker 9/9/02 at 33 ("We expect markets to control cost for us, but we don't like it when they eliminate the cross subsidies that allow hospitals, for example, to provide things like indigent care.").

[207] G. Lynn 3/27 at 86. *See also* Opelka 2/27 at 180 ("Cost shifting was once the remedy to ensure a stable practice, but this [is] no longer a solution for surgeons."); Mansfield 4/25 at 88-89 ("[A]cute care hospitals, … [are] very dependent upon being able to cross subsidize the losses we have for patients who have medical DRGs by treating those who are surgically or procedurally oriented."); Joyce Mann et al., *Uncompensated Care: Hospitals' Responses To Fiscal Pressures*, 14 HEALTH AFFAIRS 263, 263 (Spring 1995) ("Hospitals historically have taken it upon themselves to fill some of the gaps in the U.S. health insurance system by treating uninsured patients and then charging more to those who can pay to offset the costs. This practice, known as cost shifting, distinguishes the hospital sector from nearly all other sectors of the economy.").

of care to the poor.[208] More recently, the MMA includes a provision for $250 million in extra payments to hospitals in states that border Mexico, to pay for the costs of providing emergency care to undocumented aliens.[209]

Reliance on cross-subsidies, instead of direct subsidies, to ensure access to care makes the availability of such care contingent on the location in which care is provided, the wealth and insurance status of those receiving care at any given hospital, and the un-competitiveness of the market for hospital services. Several panelists noted that in some communities, hospitals make substantial profits on one group and use those funds to provide charity care to the balance of the community.[210]

In other locations, this approach is not viable – particularly if those paying the bills identify alternative locations to provide care that choose not to engage in cross subsidization. Cross subsidies distort relative prices, resulting in inefficient decisions by payors and patients. Cross subsidies also complicate attempts to provide consumers with better price information. Finally, it is generally more efficient to subsidize directly, rather than pay higher prices elsewhere and cross subsidize.

## XIII. CROSS SUBSIDIES AND COMPETITION

As noted previously, cross subsidies require either the exercise of market power by a non-profit-maximizing firm, or a non-profit-maximizing firm that receives supra-competitive profits on some services in a market with barriers to entry. As competition becomes more effective in hospital markets, these cross subsidies will tend to be competed away.[211]

Competition can help make health care more affordable, but it cannot transfer resources to those who do not have them. SSHs and ASCs may well enhance quality of care, lower prices, and improve access. From the perspective of those receiving care at the SSH or ASC, that is a desirable outcome. From the perspective of the general hospital that relied on specialty care to cross subsidize unprofitable patients and services, and from the perspective of such patients and

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[208] MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: RETHINKING MEDICARE'S PAYMENT POLICIES FOR GRADUATE MEDICAL EDUCATION AND TEACHING HOSPITALS (1999), *at* http://www.medpac.gov /publications/congressional_reports/august99.pdf.

[209] *See* Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, Pub. L. 108-173, tit. X, § 1011, 117 Stat. 2432 (Dec. 8, 2003). *See also* U.S./MEXICO BORDER COUNTIES COALITION, MEDICAL EMERGENCY: COSTS OF UNCOMPENSATED CARE IN SOUTHWEST BORDER COUNTIES 47 (2002) (estimating more than $200 million or about 25 percent of the uncompensated costs border hospitals incurred resulted from emergency medical treatment provided to undocumented immigrants), *at* http://www.bordercounties.org/vertical/Sites/{B4A0F1FF-7823-4C95-8D7A-F5E400063C73}/uploads/{FAC57FA3-B310-4418-B2E7-B68A89976DC1}.PDF.

[210] G. Lynn 3/27 at 29.

[211] *See supra* note 206.

perhaps others that the hospital serves, the same outcome is undesirable.[212]

Competition has a number of effects on hospitals, including the potential to improve quality and lower costs. Competition will also undermine the ability of hospitals to engage in cross-subsidization, however. To address this issue, Congress and state legislatures should consider whether direct subsidies for desired conduct are advisable.[213]

[212] *See, e.g.*, Lesser 3/27 at 17-18 ("While specialty facilities may lead to improved access for certain services … there may be a cost from the broader system and societal perspective [] in terms of the ability of general hospitals to maintain the cross-subsidies necessary to fund other less profitable services.").

[213] *See* COUNCIL OF ECONOMIC ADVISORS, ECONOMIC REPORT OF THE PRESIDENT, at Ch. 4 (2002) ("Competition need not threaten the quality of care received by those with the least ability to pay; rather, government support and oversight can be better directed to ensure that all Americans are able to participate effectively in a competitive health care system.").